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ABSTRACT

This publication, consisting of 16 papers presented at a 2-day conference in Summit, New Jersey, focuses on the practical aspects of caring for infants and toddlers in day care centers. The papers are categorized under six areas reflecting the following major issues addressed in the conference: developing an appropriate curriculum, selecting and training caregivers, maintaining effective relations with parents, meeting young children's caretaking needs, and designing the physical environment in an infant day care center. A bibliographic list, offering additional reading materials on the above issues, is included. (Author/MP)

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caring for infants and toddlers: what works, what doesn't

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Edited by
Roger Neugebauer,
Child Care Information Exchange
and Robert Lurie,
Summit Child Care Center

SUMMIT CHILD CARE CENTER, in Summit, New Jersey, is a model for the delivery of quality educational child care. Operating in five centers, the non-profit community agency is based in an \$800,000 child care facility designed to meet the needs of young children. Now in its 26th year, the Center serves over 500 families per day in programs ranging from infant care to school-age care. It has nearly ten years experience with infant/toddler care.

The Center has a state and national reputation for quality innovative programs. An NBC news special report stated that the Summit Child Care Center "works smooth as silk." The state of New Jersey noted that the Center not only "has an outstanding building, administration, staff, and program . . . but is a place children love and loves children."

For more information about the Center, contact SCCC, 95 Morris Avenue, Summit, NJ 07901.

CHILD CARE INFORMATION EXCHANGE is a magazine designed specifically to help day care and nursery school administrators better perform their endless responsibilities. CCIE provides practical ideas on fundraising, leadership, business management, staff motivation, parent relations, evaluation, marketing, advocacy, and director burnout. A one year subscription (six issues) to CCIE costs \$15. For more information about the magazine contact CCIE, 70 Oakley Road, Belmont, MA 02178.

CARING FOR INFANTS AND TODDLERS: WHAT WORKS, WHAT DOESN'T, a two-day conference co-sponsored by SCCC and CCIE, was held in Summit, New Jersey on April 26-27, 1980. The conference brought together 21 resource people (listed inside back cover) and 225 participants to address the practical aspects of caring for infants and toddlers in day care centers. The members of the Conference Planning Committee included:

Cam Williams, Chairperson

Ginny Barden
Pam Williamson
Kay Sachs
Carol Thomason

Diane Johnson
Vicky Tulloch
Nel Beaumont
Phyllis Wilhelm

CARING FOR INFANTS AND TODDLERS: WHAT WORKS, WHAT DOESN'T

**Edited by
Roger Neugebauer, Child Care Information Exchange
and
Robert Lurie, Summit Child Care Center**

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As day care becomes recognized as a necessity for families to function successfully, the traditional debate about whether day care is good or bad for children is gradually being replaced by more practical concerns. This is particularly true in the areas of infant and toddler care, where, perhaps because of the controversial nature of the subject, little attention has been focused on questions of practice. It is out of this need that this conference and book of readings developed. Here the question is not "Should there be infant and toddler care?--this is a question for individual families to answer for themselves. Rather the concern is "How should infant and toddler care be organized and operated?" In planning the conference we have drawn upon the expertise of a wide range of practitioners to provide answers to this question.

This book of readings is organized around the major issues addressed in the conference--how to develop an appropriate curriculum, how to select and train staff, how to maintain effective parent relations, how to meet young children's caretaking needs, and how to design the environment. Within each of these five areas the focus of the readings selected was determined by the interests expressed by conference participants when they registered.

Six of the readings were developed specifically for this book. These include the three readings in the "Parent Relations" section, the two Aronson articles in the "Nitty Gritty" section, and Lurie's case study in the "Environmental Design" section. The remaining articles were selected from existing infant-toddler literature, based on their relevance to the needs of practitioners.

Because of the considerable expertise possessed by conference resource people, an effort was also made to draw upon their ideas for this book. As a result, nine of the resource people made contributions--Susan Aronson, Alice Honig, Ellen Galinsky, William Alexander, Phyllis Silverman, Sheila Abramowitz, Janice Miller, Robert Lurie, and Roger Neugebauer.

We hope that this collection of readings, with its focus on practice, will be helpful to groups and individuals struggling to open and operate high-quality infant-toddler centers. In addition we hope it will concentrate attention on the need for more literature and technical assistance on the "how to" aspects of infant-toddler care.

Roger Neugebauer
Robert Lurie

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I overriding issues

Some Precautions in Establishing Infant Day Care

BY BETTYE M. CALDWELL, Ph.D.

We have shared ideas with one another about ways to conduct infant day care. We have seen examples of living working models. We have been alerted to some of the types of controls we must introduce into programs in order to assure a healthful environment for young children. We have discussed settings in which infant day care can be conducted successfully, and have reviewed procedures that must be followed in obtaining a license to operate a program and in making certain that state and local standards are met in program operation. Also we have reviewed

ways that administrators and teachers can sharpen their powers of observation in order to make at least informal assessments of whether the developmental progress of the children participating in such programs are adequate.

Probably the tone of this entire effort might be described as offering encouragement to would-be infant day care operators. We have tried to stress the idea that day care is not as difficult as we sometimes seem to imply that it is, that there is perhaps nothing so magical about age three which would indicate that a child care program is both difficult and dangerous prior to that time. And, to be sure, we have brought forth information to support the point of view that intervention is often desirable. Infant day care became taboo throughout the world because many well meaning people, deeply concerned with the welfare of young children, made a false assumption. The assumption was that removal of an infant from the care of his own primary family group for a few hours a day was equivalent to total removal from the family

Bettye M. Caldwell is a Professor of Child Development at the University of Arkansas at Little Rock.

Reprinted from Perspectives on Infant Day Care (Richard Elardo and Betty Pagan, Eds.) with the permission of the Southern Association on Children Under Six (SACUS), Box 5403, Brady Station, Little Rock, AR 72215.

group--that is, was qualitatively indistinguishable from institutionalization. We have now accumulated enough information to persuade us that there appears to be no substantive identity between full-time institutional care and part-time child care such as we have in the ordinary day care setting.

But in removing the taboo we would be well-advised to keep a few precautions in mind. In the human services field we have all too strong a tendency to let our convictions swing from one extreme to the other. Thus at this stage in history, though it seems that we are justified in saying that day care need not necessarily be harmful, we must be very careful not to appear to be claiming that day care during infancy should be made available to all infants, that it is the answer to the needs of disadvantaged children, or that it will solve the problems of the low-income family where the mother needs to obtain gainful employment. The surest way to kill it off is to promise too much for it. Anyone planning to put an infant day care program into operation is obligated to establish a mechanism for assessing the impact of that program on the children and the families who are served. Some informal ways that program operators can make certain that the children in their program are progressing satisfactorily, have been described. Obviously there are also carefully standardized assessment techniques which can provide us with perhaps more elegant evaluation data. But in the absence of skilled people who can use such techniques, the teachers, and administrators who operate programs need to hone their own observational powers to the point where each child's reaction to the program is noted and cumulatively analyzed as a basis for program planning.

One thing I do not want to do is to increase your anxieties about attempting infant day care. At the same time, however, I would like to mention a few precautions that I think you might keep in mind as you undertake your respective ventures.

OVER STIMULATION

Do not try to overwhelm the infants with

too much stimulation. Often those who work from a compensatory model--and basically I would classify myself in that category--are tempted to try to obtain "everything" that a baby might need or might be able to utilize and to put so many materials at his disposal that he is overwhelmed. The same can be said for too much adult personal and social stimulation. I am sure that those of you who have or have had young children have experienced the phenomenon of having one of your children fumble through a richly-laden toy box and quickly throw everything inside out on the floor, then stand up, possibly rub an eye, and look up at you as though to say, "Why don't I have something to play with?" The same kind of overwhelmed reaction can occur in the richly furnished, carefully planned day care center. The purpose is not to overwhelm nor to introduce everything at once. The purpose of selecting and making available play materials is to give the child just the right amount that he needs in order to pace his own development. If we give him too much we do not really know at this point whether the effect will be rather like what many have assumed to be the reaction to being given too many vitamins--the system will simply ignore the excess (although we know there are some who are now challenging that point of view). The reaction might just as likely be similar to that which occurs when the newborn infant is given too much oxygen. His system cannot totally ignore the excess, and delicate cells of the retina may be permanently damaged. More than anyone else I know of who has been concerned with infant care, Dr. Sally Provence has stressed the importance of avoiding overstimulation for children in groups. They need islands of quiet and serenity, she reminds us. It is well that we always remember that need.

UNDER STIMULATION

After the previous precaution, it might appear somewhat contradictory to turn around and say that there are also dangers of under-stimulation, but there are. And in my experience here the greatest danger comes from understimulation in the personal-social area. It is very easy in today's market to

find an array of exciting and challenging play materials, to make these available to young children, and then to assume that we have done all that is needed. As a matter of fact, I personally consider some of the recommendations that one finds in current educational writings to be almost dangerous on this point. You are perhaps not going to agree with my reactions here, but possibly you will permit me to be a bit personal and even a bit vehement. First to be personal. I have the distinction of being probably the only person in the country who ever wrote a manual for Head Start (for free) which was rejected by the Early Childhood Education consultants for Head Start. It was condemned as being "too structured" in 1965. It is not inaccurate to state that it was probably considered too "unstructured" in its recommended daily schedule by 1967, for by that time everyone had to have a curriculum with 300 days of carefully sequenced activities per year. Now suddenly the "free" schools are again the thing, and we constantly hear such expressions as "children learn so well from one another, why should adults be their main teachers"; or "I wonder what we are depriving children of learning when we teach them something." Granted that such recommendations call for hidden and implicit adult influence, I do not like the point of view which attempts to minimize the importance of adults in the lives of young children, especially very young children. All the data we have contradict such a recommendation. That is, infants in institutions where there are many infants and few adults do not develop well. Children in large families whose interactional stimulation from adults is diluted develop more slowly and have more learning difficulties. Recommendations that adults withdraw from the teaching-learning experience and "let the children interact with the materials" are setting the stage for peer-oriented cultures and for alienation between children of any age and the adults with whom they must interact in a complete society.

Now to leave the vehemence and continue with the remainder of the principle--in an infant day care setting it is very easy to persuade ourselves that all we do is to buy the toys and the materials and sit back and let the children utilize them. Here again

a reference to what has been noted in infants in institutions might be worth while. As we well know, the stereotyped gray-walled institution has pretty well disappeared in most parts of the world; however, there are still institutional settings in which young infants do not have enough people to take care of them but where occasionally they do have an acceptable array of play materials. It has been observed that the children fail to play with toys in such settings. Probably the best interpretation of this is that there have not been meaningful adults who could invest the toys with value. Thus I caution again that an infant day care setting in which the adults are not animated, interactive, verbal, and loving people, will most likely be an under-stimulating environment for infants.

WEAKENING PARENT-CHILD TIE

Weakening the parent-child tie was certainly one of the main things that we worried about in beginning to set up infant day care. Would a child care arrangement in which the very young child spent a significant portion of the day in the company of adults other than his parents weaken or distort the emotional relationship between that child and his parents? That was an extremely important question five years ago, and it is just as important now as it was then. The only firm data we have on it has come from the Syracuse infant day care project with which I was formerly affiliated (Caldwell, Wright, Honig, & Tannenbaum, 1970). A group of 18 infants who had been in a day care setting from around one year of age was compared to a control group of 23 infants who had remained at home during that time in the care of their own mothers. All the children were evaluated when they were approximately two-and-one-half years of age. The children were observed in interaction with their mothers and were rated in terms of the apparent strength of attachment to the mothers. Conversely, the strength of the mothers' attachment to their infants was also rated. The main question asked by the research was: Would the day care children be less attached to their own mothers? The results were very reassuring. There were no sig-

nificant differences between the home reared and the day care infants on any of the ratings of the child's relationship with his mother. Similarly, the mothers of the home reared infants were no more attached to their own infants than were the mothers of the day care children. In fact, the only significant difference between the samples was in favor of the day care mothers, who were judged to be more permissive and accepting of their infants. These data offer reassurance that a weakening of the child-mother tie does not have to occur in a day care setting. However, this is the only study of its sort to date that I know of, and we need to replicate it in virtually every day care setting in the country before we can feel complete confidence on this point.

I have already referred to our well-known tendency to swing like the pendulum of a grandfather's clock with no walls to stop its movement. One precaution that a program planner must keep in mind, therefore, is to avoid the development of an unbalanced program. It is possible to have too much emphasis on cognitive development. And it is possible to be so concerned with social and emotional development that one neglects the cognitive area. And it is possible to place too much emphasis on motor development, or art activities, or music--or what have you. One strategy that we must keep in mind in any very early childhood education program is that we are basically keeping opportunity's gates open for the child. We want to give him as many options as possible for the later developmental periods when he himself will be in a better position to choose what he wants to do and to give more shape to what he wants to become. Thus I plead for a balanced program, one whose objectives cover all the developmental areas and whose daily organization permits a balance between teacher-initiated and child-initiated activities, between quiet activities and vigorous activities, between convergent learning requirements and divergent learning opportunities.

Another precaution I would offer has to do with the length of the day. Day care has grown up within the tradition of a service that lasts for an entire day. And yet there is no reason why it cannot be

planned flexibly within a time dimension. Yes, it might disrupt your program to have a child come in at 11:00 rather than 8:30 a.m. when you want to begin your activities, but can you adjust to it if it means having him remain at home with his mother after all the other children have gone to school? And can you arrange it so that a mother could bring a baby in at 1:00 p.m., when you have just bedded down the rest of your group and do not wish to have any of them awakened? I used to object to such things and told myself that the babies couldn't adjust. Now I know that the babies can adjust and that it was I who found it difficult. But with day care becoming an increasingly more potent force in the lives of children, and with the pressures on the part of some parents to make supplementary child care available on an almost permanent basis, day care administrators must be alert to subtle ways of sharing the child care responsibility with parents. We should not have to have a child enrolled either nine hours or not at all.

The final precaution I would mention I have called Parent Teacher Avoidance--PTA. Don't let it happen if you can possibly avoid it. In a meeting last summer during which a number of professionals and parents were asked to help prepare a series of manuals on day care, there was a great deal of heated discussion about the amount of control that parents should have. I feel something of a reactionary in such discussions, because I do not advocate "parental control" of day care. Nor do I advocate "teacher control." Rather I advocate an assumption of shared responsibility for the welfare of the children whose development is being guided jointly by the home and the day care setting. But as I listened to the heated discussion I found myself reflecting on the many attempts we have made to involve parents, to get them to want to exert control, to urge them to spend time with us in the Center, to share their ideas, to communicate their desires and wishes for their children--often to little or no avail. Thus my final precaution is simply that you use every wile and every device at your disposal to prevent the establishment of parent-teacher avoidance. If you have parents who seem to avoid such contact,

try hard not to let this occur. Similarly, do not permit yourselves to avoid parents who are difficult, who complain, who never seem to appreciate all the wonderful things you are doing for their children, and so on. You have entered into something of a sacred contact with the parents. Be creative in your attempts to keep the contract binding and not let it become a one-sided arrangement.

SUMMARY

In our new willingness to consider the advisability of child care programs for children under three, we have broken another barrier: we have crossed through a previously impermeable membrane and recognized the absurdity of assuming that human development can be rigidly divided into different segments. The child younger than three is engaged in a fascinating developmental process and has an array of developmental needs which can be met by the social and physical environment in which he must develop. Having recognized the artificiality of the age boundary, and having analyzed the developmental needs of infants and the growth inducing experiences which can be arranged by the caregiving adults, we are now ready to move forward with some creative and far-reaching plans for young children and for the older children and adults they will eventually become.

REFERENCES

Caldwell, Bettye M., Honig, Alice S., Tannenbaum, Jordan, Wright, Charlene M. 1970, 40, 397-412. "American Journal of Orthopsychiatry," Infant Day Care and Attachment.

Meet the Voices that Speak for Children – Brazelton, Fraiberg, Kagan, and White Discuss Infant Care

by Bonnie Neugebauer

Most of us will never have the opportunity to meet the people who are the most influential voices on human development face-to-face--or better yet, to watch and listen from the sidelines as they face each other in a discussion of theories and convictions on infant care. To hasten the day of such an opportunity for us to clarify our understandings in order to form our own viewpoints, the voices who speak for children have been brought together in mind, if not body, in this panel discussion of my invention.

Bonnie Neugebauer teaches and operates *Beginnings*, a home-based toddler nursery school in Belmont, MA.

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The ideas presented here are quotations taken directly from books, articles, and interviews. Every effort has been made to accurately present each idea. The only alterations have been for the purposes of this conversational style of presentation.

So imagine for a moment--T. Berry Brazelton, Pediatrician and Chief of the Child Development Unit at Boston Children's Hospital Medical Center; Selma Fraiberg, Professor of Child Psychoanalysis at the University of Michigan and Director of the Child Development Project; Jerome Kagan, Professor of Developmental Psychology at Harvard University; and Burton White, Director of the Center for Parent Education in Newton, Massachusetts, are seated in easy chairs, television-interview fashion, as the moderator begins--

MODERATOR: As parents, teachers and directors of child care programs,

we would be interested in hearing what you consider to be the most critical period of development in the life of a child.

WHITE: Based on 20 years of almost full-time research into the full development of the human being, we have come to the conclusion that sometime around eight months or so is the time when right now attention has to be paid if we're going to make any significant dent in this question of how to help a child develop well. I say this partly on the basis of what we've done in studying specifically and most centrally good development. We've been in homes where kids are developing beautifully, and from watching these we see that children pull away from the pack somewhere during the second year of life. The other side of the coin is that children start to drop back at about the same time--if they're falling behind. You can't predict where a kid is going from his achievement at one, but you can at two. (10)

KAGAN: This suggestion that early experience is the primary force is partially satisfying because it resolves uncertainty, provides rituals that reduce parental anxiety, makes material encounters between the child and his environment the bases for negative outcomes and, above all, is rational. (5, page 148) But recent discoveries about the infant imply that his first experiences may be permanently lost. The fears and joys of the first year seem to be part of nature's script for development, not harbingers of adolescent anxiety or prophetic signs of childhood happiness. I suspect that it is not until a child is five or six years old, when he has begun to crystallize a symbolic conception of his personal qualities and styles of interacting with friends and family, that we get a more reliable preview of the future. The infant's mind may be more like a sandy beach on a windy day than a reel of recording tape. (9, page 104)

BRAZELTON: It would be useful to have

a series of scales which uncover the thought processes and the ability of the child to combine ideas to reach a goal. To this end, Sybille Escalona is combining some of Piaget's ideas into a scale of development. By assessing the young child we could better predict performance and stability for later years, as well as pick out the infants who were at risk for the more complex demands of society. The latter could be offered environmental stimulation which was appropriate to their needs, and which might provide them with better experiences to build upon. Unless this experience is offered as early as possible, the chances of salvaging most such children are passed by the ages of four or five years. (2, pages 39, 40)

MODERATOR: But do you think there is a critical period for the attachment between mother/father and child?

BRAZELTON: Leaving a baby before the worst hurdle of adjustment is over and before enjoying the rewards of having made it together (not until at least three months) is unfair to both mother and baby. They will never again have such an opportunity for cementing their bonds and learning about each other. Sharing this early period with substitutes means diluting it. It is time that our society began to value the well-being of its future citizens. Women's roles need more responsible thought. In communal societies which have been established long enough to realize the significance of this early critical period for mothers and their babies, most have established laws which protect and foster a mother's being at home for the first six months. We don't know the exact length of the critical period, and it may be very individualized, but an option must be there for all women. (2, pages 176-177)

FRAIBERG: We have learned that those mental qualities which we call "human" are not part of the constitutional endowment of the infant, are not instinctive as are the characteristics of other animals, and will not be acquired simply through maturation. The quality of

human love which transcends love of self is the product of the human family and the particular kind of attachments that are nurtured there. The quality of human intelligence which depends very largely on manipulation of symbols, especially language, is not simply the product of a superior mental and vocal apparatus; it is achieved through the earliest love attachments. Man's consciousness of himself as a being, the concept of "I," of personal identity--the very center of his humanness--is achieved through the early bonds of child and parent. The triumph of man over his instinctual nature, his willingness to restrict, inhibit, even to oppose his own urges when they conflict with higher goals for himself, is again the product of learning, and achievement through love in the early years of development. Conscience itself, the most civilizing of all achievements in human evolution, is not part of constitutional endowment, as any parent can testify, but the endowment of parental love and education. (3, page 301)

MODERATOR: What is the parent's role during the child's first years?

KAGAN: We wish to take a strong stand that when food and protection from excessive disease and physical discomfort are guaranteed, children do not require any specific actions from adults in order to develop optimally. There is not good evidence to indicate that children must have a certain amount or schedule of cuddling, kissing, spanking, holding or deprivation of privileges in order to become gratified and productive adults. The child does have some psychological needs, but there is not a fixed list of parental behaviors that can be counted on to fill these critical requirements. (7, page 6)

FRAIBERG: It does appear that parents need not be paragons, they may be inexperienced, they may be permitted to err in the fashion of the species to employ sometimes a wrong method or an unendorsed technique, and still have an excellent chance of rearing a healthy child if the bonds be-

tween parents and child are strong and provide the incentives for growth and development in the child. For the decisive factors in mental health are the capacities of the ego for dealing with conflict, the ability to tolerate frustration, to adapt, and to find solutions that bring harmony between inner needs and outer reality. These qualities of the ego are themselves the product of the child's bonds to his parents, the product of the humanizing process (3, pages 301-302)

BRAZELTON: In spite of an avalanche of advice, of "sure" ways to mother a child, a new mother must realize that no one of them is the only answer. She must find her own way as a mother with her own special baby. Each mother and baby is an individual. As such, each pair is stuck with its own ways of interacting. The idealized suggestions of an authority may be entirely wrong for a particular mother and her child. A young mother may be better advised to chart her own course via the markers set out by her own baby. I am impressed with the accuracy and depth of insight that is a mother's intuition. A new mother has deeply ingrained responses and capacities with which she will react to her babies. Because of this, she will begin from the outset to reinforce the differences in each infant. (1, pages xvii, 1-2)

WHITE: Basically I base my recommendation on direct research on the problem and on very strong correlations between things parents do and achievement rates in children. Brazelton bases his recommendations on his work as a pediatrician. You have to question in your own minds what kind of research is most germane to which issues. Statements as to what a child ought to have are much cheaper than a dime a dozen. There's no substitute for having something in the way of reliable knowledge. Now the average parent, even the sophisticated one, is not aware of the details of development. You can be as loving as you want and still be totally unaware of what a kid is going through. The average parent certainly knows that with the first kid they learn the hard way. Love isn't enough. This is a job for a professional or semi-professional or at least trained

people. (10) Most American families get their children through the first six to eight months of life reasonably well in terms of education and development; but I believe that perhaps no more than ten percent at most manage to get their children through the eight- to thirty-six-month period as well educated and developed as they could and should be. Yet our studies show that the period that starts at eight months and ends at three years is a period of primary importance in the development of a human being. (11, page 4)

MODERATOR: Do you feel that if a child does not receive optimal care in terms of environment and parenting during the first three years, he will never be able to reach his full potential?

WHITE: To some extent I really believe it is too late after age three. (11, page 257) Nobody can say never until we've exhausted all the different ways of trying to reverse or upgrade or make up for relatively poor development. I don't think we'll ever exhaust all those ways. We can't talk in terms of absolutes--let's talk in terms of likelihoods. In the past 12 years we've invested as a nation far more than any other nation ever dreamed in that particular issue. Take the kid who at three looks weak and let's see what we can do for him, either in special education later on, or Head Start or something else. The answer has been poor results for many of them. This argues all the more heavily in terms of prevention--which is what people thought Head Start was going to be anyway, without understanding that three is late. (10)

KAGAN: Many still believe as you do that most of an infant's experiences have effects that reach many years into the future. This belief that development is continuous and cumulative leads parents to conclude that in order to prevent undesirable behavior and to promote desirable conduct, caretaking adults must provide the baby with a certain recipe of encounters. If

adults fail in this mission, the infant will not develop its potential or will be vulnerable to future unhappiness. Recent evidence, from studies that have followed children for many years as well as from the laboratory and from other cultures, seems to contradict this ancient belief. I'm trying to be a reasonably cautious person, but what I can say with confidence is that an abnormal experience in the first two years of life in no way affects basic intellectual functions or the ability to be affectively normal--to experience gaiety and sadness, guilt and shame. (9, page 99) Malnutrition and disruption of normal family experiences during the first two years of life only predict later impaired cognitive development if the child remains in the same destructive environment. Development can be affected benevolently if the child is exposed to new experiences or contexts that sculpt the skills required for successful adjustment. (9, page 142, refers to Richardson 1976)

BRAZELTON: My own conviction is that each child is born with particular strengths and marked individuality. These individual differences influence the parents and all people around the child as much as they, in turn, will affect him or her. A child can absorb a great many mistakes on his parents' part. At the same time, however, every child deserves an environment responsive to his individual needs, one which can change as he changes. Parents do not need to be loaded with helpless guilt, anticipating the errors they will make with their child. By implying that all responsibility is on parents, we are saying that unless parents find the one right way, any mistake they make will ruin the child. This creates a heavy burden of anxiety for a parent who cares. (2, pages x-xi)

FRAIBERG: Children who have been deprived of mothering, and who have formed no personal human bonds during the first two years of life, show permanent impairment of the capacity to make human attachments in later childhood, even when substitute families are provided for them. The degree of impairment is roughly equivalent to the degree of deprivation. The mending of children's lives is a very

large part of the work of my profession. It would be folly to say that all childhood disturbances of personality can be prevented, but a large number that I have seen could have been prevented; and in nearly every case these have been caused by disturbances in the primary human relationships during the early months and years of life. (4, pages 59, 134)

MODERATOR: Can child care centers provide substitute mother care for young children?

FRAIBERG: The question must be raised whether these institutions are actually providing "substitute mother care" for babies and preschool children. With luck and perseverance some mothers have found an extraordinary day-care center in which the principles of child care are derived from the psychological needs of babies and small children, programs in which exceptionally qualified teachers or aides provide mother substitute care, highly individualized for each child, consistent and mindful of the needs of the small child for continuity in relationships. I myself know of only a handful of day-care centers in this country which operate on these principles. (4, pages 92, 97)

WHITE: Day care is a fast moving field, and it varies dramatically from centers that are expensively designed and very carefully supervised and run all the way down to strictly custodial, extremely inexpensive operations. I haven't come away from many of the centers I have visited feeling that the people who are staffing day care are particularly knowledgeable about the details of human development. Generally, in the better centers, there is one key person who is very well-trained, sometimes more than one. But on the whole, across the country, the typical staff person is working strictly on an intuitive basis. What isn't good enough for a mother is clearly not good enough for a staffer. (10)

KAGAN: We have shown that if the ratio of children to caretakers is not large,

the staff is conscientious and well supervised, and there is some professional monitoring of the child's development, group care does not seem to have an important effect on the infant's development. The attributes that are of importance among caretakers include a fondness for children, prior experience in raising children, some knowledge of child development, and a tolerance for the views of others. (5, page 265)

WHITE: But we have no day care centers that have demonstrated that they somehow or other have some substantial clout to deliver to children. Now even when you look to Kagan's recent venture into day care you don't find any claims there for any dramatic educational gains for children. You also find no claim that attachment has been ruptured or that anything harmful happened; but bear in mind that you can't compare Kagan's center with day care across this country. His was an \$85 a week program /1976/, very carefully supervised and staffed--and that isn't typical of the country. So the fact of the matter is that the field doesn't have a track record from which it can say--use us, we're solid, we're good. (10)

KAGAN: If you mean our center was carefully thought out--it was that. If you mean it was fancy and highly-staffed and full of expensive toys and equipment, then you're wrong. (6, page 12)

BRAZELTON: Separation is often more of a problem for the parent than it is for the child, at the time. I'm sure that there is some deeper cost for the child which cannot be measured in observable behavior. But if the center provides a warm, nurturing environment and cares about the child, he or she can gain a great deal to compensate for it. Learning about other children and adults, learning how to handle feelings in the many situations which a center provides, can be a real opportunity. Most families in our society must depend on alternatives today. Unfortunately there are many grossly inadequate centers, poorly staffed, or lodged in homes which are patently

dangerous for the children. We must move to correct this by providing more safe and enriching centers for young families. (2, page 185)

MODERATOR: At what age can a child handle a substitute care situation?

KAGAN: A child should not be admitted to the day care center before four weeks of age. Mothers should be encouraged to enroll the infant in the center between one and seven months or after 18 months. (7, page 72)

FRAIBERG: There must be one or more persons who remain central and stable in the early experience of the baby so that the conditions for early memory function be present. Such a central person must be associated with pleasure and need gratification because memory itself becomes selective through the emotional import of experience. In developmental terms, the child at the age of three can transfer some part of the trusting relationship with his parents to a caregiver or a teacher who knows how to earn the trust of children. When the primary consideration is substitute care for a working mother employed full time, however, the 9- to 10-hour-a-day group program can strain the child's tolerance to its limits. Children at all ages are endangered by indifferent caregivers. But children under the age of six are endangered during the most critical period of development. (4, pages 67, 98, 100, 153)

BRAZELTON: Although I would certainly always prefer an intact mother-child unit, there are many times and many situations where the child may be better off in a shared environment. (2, page 85)

WHITE: My feeling is that if a mother is aware of the importance of what is going on in a child's development at this point, she will be more likely to stay home at least part of the day. (11, page 148)
Watching what happens as children move

through these first couple of years, I have become impressed with how much one on one seems to be involved in good development. When children first start showing their first awareness of pride in achieving something, and start testing people, and enter into their first episodes of make-believe, the people who respond, who care the most, who help them proliferate, who enhance the child's enjoyment, are the people who value that kid's utterances more than anyone else's. For reasons of shaping a human being, I think the average kid will do much better in his own home or in the care of someone who has a special relationship to that child and doesn't have a group of children to relate to. (10)

MODERATOR: What makes a child care center good?

BRAZELTON: Many day-care centers have been too impersonal in the past, and have not paid enough attention to having one caretaker take care of a child--one who likes the child and who can relate to the mother. Fortunately, these attitudes are improving rapidly in most centers, and the new and exciting focus in day-care training is on the mother-child unit rather than just on the child. In every case in which the effects of day-care have been studied, the positive gains on the part of the child are directly correlated with the kind and amount of involvement provided for the parents. Carry-over of nurturing into the home is perhaps the most important benefit that a caretaking center can offer a child. (2, pages 31, 32)

FRAIBERG: All children at all ages need stability, continuity, and predictability in their human partnerships for the fullest realization of their potentials for love, for trust, for learning and self-worth. A mother who is in tune with her child, sensitive to his signs and signals, his unique patterns of personality and his idiosyncrasies, will want no less in a substitute mother. She will want a mother substitute who finds pleasure in babies and small children and who values

a child's love. Such a person would also feel that care of a child is a personal commitment and that if she has earned the affection of a small child she would not capriciously change jobs or desert the child and the family to whom she has bonds of affection. (4, pages 94, 96)

KAGAN: As I mentioned before, the attributes that are of importance among caretakers include a fondness for children, prior experience in raising children, some knowledge of child development, and a tolerance for the views of others. The parents of the children in the center should be able to effect changes in the institution when they feel their child is developing anomalously. (7, pages 70, 71).

WHITE: Basically what it boils down to is you're talking about custom work which is best done one unit at a time. Having to be spread to the point where it's three to five people makes it impossible to do some things, in my opinion. I don't want to be hung with the label--he's against day care. I'm not. Day care has two purposes, and people tend to get those mixed up. The primary purpose is for the adults. The secondary purpose has been the child. Day care wasn't conceived of first of all as a way of doing good things for kids. It was conceived of first of all as a way of making family life better while coping with special problems. (10)

MODERATOR: Would you endorse some sort of national policy that would provide an income for a mother to stay in the home?

WHITE: Absolutely. We had that years ago. It's not news. That's what we had in the early 30's /Aid to Dependent Children, 1936/. The assumption was that the mother belongs in the home with her kid. Now I'm not saying that that's true. I'm not saying that a mother has to stay at home with her child, but I don't like the

idea of having no choice. That is poor planning. (10) I believe that fathers, mothers, and day care centers are all capable of providing an excellent early education for children. All things being equal, I think mothers will probably do better at the task than others. (11, page 256)

BRAZELTON: Having a fulfilling role besides being a housewife may well give a mother more positive feelings and less negative ones with which to surround her children. The current problem is how to do this best for both parents and children. We cannot afford to continue to ignore the deprivation, the loneliness, the ambivalent depressed atmospheres in which many of our children are being raised. We must look for a variety of solutions, among them ways of freeing working mothers of helplessly complicated guilt feelings so they can do both jobs well. Foremost should be our concern for the welfare of our children. But the psychological welfare of the parents cannot be divorced from this. (2, page 34)

FRAIBERG: I believe that families should have incentive to become self-supporting. But there are six million children in the AFDC families with female heads who require substitute mother care if their mothers are employed, and the services which are provided by Child Care Industries Incorporated do not provide substitute mother care. In fact, they are, typically, child storage houses, staffed by care-givers who are mostly indifferent and often outrageously neglectful. If AFDC policy requires her to work, or offers incentive to work, the mother's own knowledge of what her child needs is practically irrelevant. If the additional income from her lowpaid job provides her child with at least minimum adequate nutrition, she may have to weigh that fact against the psychological risks for her baby or young child. If the AFDC mother chooses the debasing alternative of welfare, we do not have to impute sloth, cunning, and apathy to her motives. It is just as likely that she is a woman who cares about her children and has the basic intelligence required of all of us

to manage fourth-grade arithmetic. Every social program in medicine, law, education, and public welfare must commit itself to the protection of the human rights of children, the rights of enduring human partnerships, the right to be cherished by family and community, the right to fully realize their human potentials. (4, pages 152, 168, 147, 179)

MODERATOR: Thank you all for sharing your views with us this evening.

FOLLOW-UP

None of this means anything unless each of us brings it together into some workable form in our own minds. To that end resources in the bibliography have been asterisked as suggestions for further reading. After exploring these resources individually, it might be most beneficial for staff members from your center or directors from your community to meet to discuss the following and related issues.

1. How does your program provide support for the growth and development of families? How can your support system be strengthened?
2. What do you feel is the impact of group substitute care on the development of infants?
3. In what specific ways does your center encourage parent involvement?
4. Discuss the ways you have been successful in reversing poor beginnings of specific children. Consider developing a system of documentation and a list of stimulation materials.
5. What implications do the views of these four theorists have for FIDCR?
6. What things can you do to encourage the development of a bonding relationship for infants which is reciprocal and interactive?

BIBLIOGRAPHY: Throughout the text the first number in parentheses refers to the number assigned to the sources below.

- *1. Brazelton, T. Berry. Infants and Mothers: Differences in Development. New York, NY: Dell Publishing Company, 1969.
- *2. Brazelton, T. Berry. Toddlers and Parents: A Declaration of Independence. New York, NY: Dell Publishing Company, 1974.
3. Fraiberg, Selma H. The Magic Years: Understanding and Handling the Problems of Early Childhood. New York: Charles Scribner's Sons, 1959.
- *4. Fraiberg, Selma H. Every Child's Birthright: In Defense of Mothering. New York: Bantam Books, 1977.
5. Kagan, Jerome and Richard B. Kearsley and Philip R. Zelazo. Infancy--It's Place in Human Development. Cambridge, MA: Harvard University Press, 1978.
- *6. "Jerome Kagan on Infant Care," an interview with Dennie Wolf. Child Care Information Exchange, Spring, 1978, pages 9-13.
- *7. Kagan, Jerome. "The Effect of Day Care on the Infant." A State of the Art Paper for Federal Interagency Day Care Requirements.
- *8. "Do the First Two Years Matter?" A Conversation with Jerome Kagan. Saturday Review of Education. April, 1973, pages 41-43.
- *9. Kagan, Jerome. "The Baby's Elastic Mind." Early Childhood Education 79/80. Guilford, CT: The Dushkin Publishing Group, Inc., 1979, pages 99-104.
10. An interview with Burton White conducted by Patricia Lawrence and Roger Neugebauer, October 12, 1977.
- *11. White, Burton L. The First Three Years of Life. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1975.
12. White, Burton L.; Kaban, Barbara; and Attanucci, Jane. The Origins of Competence. Lexington, MA: Lexington Books, 1979.

II curriculum development

Quality Care for Infants

BY J. RONALD LALLY, Ed.D.

In discussing quality care for infants, there are four major areas which I will address. The first is the setting or style in which an infant program, whether it be a family day care or group day care program, should be housed. Secondly, I would like to speak about the emotional needs of infants as the base for any kind of programming. Third, I would like to discuss some general child development phenomena which are particularly interesting to the children's parents and grandparents. Finally, I would like to spend the majority of the time discussing cognitive development. This may be particularly relevant since the setting and

the whole emotional climate of any program directly affects whether you succeed or fail in fostering cognitive development. As a final qualification, I am going to focus on the younger child, the infant between 0 and 18 months, although our program at Syracuse does include children up to three years of age.

THE SETTING

In considering the setting of any care arrangement the most important aspect, especially when we are caring for infants, is that we need to keep small numbers of them together. For example, we don't want to set up a large room with 36 infants in it. Infants, especially in this age group, have great difficulty handling large numbers of people. I would recommend approximately eight infants to a room with definite assignments of a child to a caregiver. It is extremely important that every child be assigned to a caregiver. Rather than having a room in which you have eight children with two caregivers generally responsible, you

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should assign four of the children to each of the caregivers.

Obviously, the caregivers have to work together to help each other with the many tasks involved. However, from the start, a parent knows and the infant knows or begins to get the feeling, that he is attached to a particular caregiver. Further, the director of the program knows that a caregiver is responsible for these particular children. The caregiver is able to follow the development of her children. She is the person responsible for checking with the nurse if something is wrong with the child. She writes notes home to the parents or confers with them when they bring the children to the center and take them home. In short, she is responsible.

When caring for children in the 0 to 18-month-old group, I would recommend consistent volunteer or back-up help. Note that I say consistent. If you are using volunteers, usually a blessing, see that they come to the center on a consistent schedule. A child at this very early age needs constancy in the people surrounding him. For example, it is a very confusing thing for an infant if 20 students act as volunteers and a different one comes in each day. It is preferable to have one person coming in every Thursday, and assisting with the care of the same children. If you do have irregularly scheduled volunteers, assign them tasks which do not involve actual care of the infants.

Finally, I would suggest a free, but not a limitless, kind of environment. Using the example of eight infants in a room, this size room might be very good. You need walls, a confined space, a defined environment for the infant to "get into." I would prefer to be able to speak about all of the things related to a setting in greater detail. All of them are negotiable and certainly you can adapt them as your program needs dictate. For example, there are ways to change the spatial climate in a room by manipulation of furniture, use of room dividers and other things. I am not trying to be dogmatic, but I do recommend that small numbers of infants be kept

together, that they be identified with a particular adult and that the environment not be limitless.

EMOTIONAL NEEDS

Before discussing directly the emotional needs of the infants, it seems important to address the general philosophy which should be inherent in any program designed to deliver alternate care services. The philosophy of the Syracuse Center is that we are the support of, rather than a substitute for the parents. Most of the literature related to child development tells us that the child imitates and identifies with the people he loves most in infancy. In the vast majority of cases, these people are the parents. Therefore, if a program attempts to substitute for the parent, problems will undoubtedly arise. I am not addressing the question, which has been raised by many, about a loss of attachment because of separation anxiety if an infant is placed in a temporary alternate daily care setting. In the case of group or family day care, the distinction is that it is not a permanent separation, it is a temporary separation. The child soon learns that every night he is going back to his parents and family. However, the important distinction to make is that the caregiver is the support to the parent. The difference lies in attitude. Does the caregiver feel that "this poor little child has such a miserable existence at home that I am going to compensate" or does the caregiver feel that "I can facilitate the interaction and bond between this mother and child by allowing the mother to see some of the things we think are good for her child." These two attitudes are quite different. In other words, if you give without letting the person you are giving to have a significant part in the action, you are not really giving, you are taking. You are taking the dignity of those people you are giving to. Programs must be modeled to support the parents.

With the support of the parents, we still want to build a security battery for this

infant. Although it is impossible to separate cognitive development from emotional development, when we talk about them we always do make that distinction. The child will not learn in an environment which is strange, hostile, or uncaring. Therefore, we must provide him with adults who have a good feeling about him. In this first period of life we must establish a basic feeling of trust between adult and child. Your first job is to establish this basic trust. It is essential for everything else you want to do. It is essential for the provision of quality care.

As I mentioned earlier, assignment of caregivers to specific children is essential. What happens is that the infant begins to perceive that this person is his caregiver and that a variety of things are happening in his immediate environment. As the infant begins to grow and learn, he ventures out from this warm secure battery of emotion that he has established with his caregiver. If he ventures too far and is threatened by the strangeness of the world, he knows that he can run back to a caring person for reassurance and a "revving up" for more exploration into the world. Without this feeling of basic trust in an adult the child is not going to venture out into the world. He is not going to explore the world which is a very risky and unloving place. All of the things which I speak about later are based on this establishment of basic trust between caregiver and child.

DEVELOPMENTAL PHENOMENA

This particular topic has caused numbers of problems for parents, grandparents, other family members and finally for programs attempting to serve families. The best way to characterize it is that parents and family members do not have a basic understanding of child development phenomena which all children experience.

Basically, adults tend to attribute adult reasoning to the child and therefore assign causes for a child's actions which simply don't exist. Three examples of this misunderstanding should help to delineate the problem.

The first is the "fear of strangers" phenomenon. Somewhere between the ages of 6 and 12 months an infant becomes afraid of strangers. What is happening here? Many of you have observed that at the beginning of life an infant will bring his arm or another part of his body to his mouth and will subsequently bite the arm or hand. The infant then cries. Yet, he will repeat the action, bringing, shall we say, his arm to his mouth, biting and then crying. The infant does not realize that he is hurting himself because he has no understanding of self. This is, of course, a very young infant that has not become de-centered enough even to have this identification. As the infant grows through the first six months of life, he gradually begins to differentiate himself from others--"the me and the not me" in the most basic terms. Those things that are "me" and those things that are "not me" become differentiated. Further, the infant becomes accustomed to some adults, particularly the principal caregiver, usually the mother, as well as others around the house. Fear of strangers between 6 and 12 months is evidence that the infant can discriminate between those adults usually around him and those not usually around him.

Let us then take a hypothetical situation. Grandmother lives nearby. She comes once a week to visit. During the first six months of the infant's life, grandmother's visits were happy occasions. She picked the baby up, held him, played with him and he responded with a smile or gurgle. At seven months, grandmother comes to visit and play with the baby and suddenly the baby begins to cry. This happens several weeks in a row and finally grandmother says to the mother, "You're turning the child against me. What are you doing to make the child like this? He doesn't love

me anymore. You're spoiling the child. He can only relate to you and not with anyone else." Thus, familial strife. Unnecessary strife.

What has actually happened is a part of cognitive development. The infant is now capable of differentiating from others the warm loving person, the principal caregiver, in whom he has trust. He grows out of this as he becomes more sophisticated. He does not discard his trust of his parents but he does become able to make more subtle differentiations between friends and foes.

As a second example, let us consider the 12-month-old infant who is beginning to experiment with spatial relationships, means-ends, and relationships between cause and effect. Again a hypothetical situation. The infant is sitting in a high chair. He has a spoon which he promptly drops on the floor. Mother picks up the spoon, gives him another which he again promptly drops on the floor. Mother decides to give him some blocks to amuse him, six to be exact. He drops all six blocks. Some he drops over there, some he throws over there and over here. Mother thinks, "This child is trying to drive me crazy. Every time that I try to feed him he takes the spoon and the food and throws it on the floor. He is going to learn that when he is being fed there are right and wrong things to do."

What the child is doing is experimenting with spatial relationships. He is experimenting with release and no release. He is trying out all of these new schemes of behaving in the world. Mother is looking at the action through her adult eyes and assuming an intent not present in the infant.

Finally, although I do not like to pin chronological dates on these kinds of things, around 18 or 20 months of age we

begin to observe negativism. This can best be characterized as the "no, no" stage. The child and the parent run into their first major confrontations of will. What the child is saying, as we look back at fear of strangers in a more sophisticated way is "Hey, look at me, I'm separate from you." Around this time the child will say no, and do the action for you anyway. Nevertheless, the child is moving along the dependence-independence continuum toward independence. Many times parents or caregivers react with, "Here it is, I knew it was coming. This is the final test of wills, of who is in control. I am in control and I am going to require 100% obedience." What the child needs most at this time is for you to require 80% obedience. For example, if you want the child to take his toys to his room or to the other part of the building he may take only three quarters of them back. Or he may put them just inside the door. He is demonstrating his sense of independence. you need to realize that this is a developmental phenomenon.

Others who have been doing research on this particular phenomenon have found that between the ages of 15 and 18 months, the number of times that the parent says "no" to the child increases approximately 300%. This is a result of the fact that the child is now more mobile, active, verbal and generally into everything. Thus, the parents use of the negative increases. If you accept this hypothesis, the child's use of "no" could be a result of imitation. I personally feel that the child is demonstrating his increasing sense of independence. Whatever the cause, this particular phenomenon is a part of the developmental process. Parents and caregivers need to deal with children as children, not as adults. I am not saying that children need be allowed to do everything. Limits must be set. However, it is better to understand what is happening from the child's view rather than the adult's view and then go about setting the necessary limits.

COGNITIVE DEVELOPMENT

There are seven major areas of cognitive development. I will give one or two examples of activities in each area. All of the activities are of a sensory-motor nature. According to Jean Piaget, the well-known Swiss child development expert, sensory-motor learning is the process that goes on through the first 18 to 24 months of life. It is very difficult for us as adults to think about sensory-motor functioning. The best example that I can give you is Helen Keller. Helen Keller was asked if she could remember how she thought before she had language. She said that ice cream to her was an itch across the palm of her hand. As they pursued that with her, she said that whenever she wanted ice cream she had to turn the crank on the ice cream maker in order to make the ice cream and then she could have it. Now, what she was describing was sensory-motor thought. As adults, we think that our thinking occurs somewhere within our heads, but the very young child's thoughts are in his senses--out in his body. He has no abstract cognition. An infant begins the growth toward abstract thought by going through manipulations of his body, hands, arms, legs, etc. He doesn't have the abstract symbols that we have. His symbols are motoric and sense symbols. That is the way he thinks.

Before reviewing the seven areas of cognitive development, there are some general principles which will help teachers who are trying to get children to become involved in learning something new. The first thing is to isolate that particular concept which you are trying to teach. For example, probably one of the most confusing toys that a very young child can have is a plastic ring stack with rings that are different sizes, different shapes and different colors. We assume that he is learning something from that toy, although I am not sure what he could be learning. A more appropriate toy, if we want to teach something about size, is one that iso-

lates size. In other words, use materials which are all the same color, all the same shape but varying in size. Then the child is forced to focus on that particular concept that you are trying to teach. Another example particularly appropriate for the child from 18 months to 3 years of age, during which time vision is an overpowering sense, is to find ways of helping the child use different senses. You must somehow find ingenious ways to isolate vision in order to give the child tactile, auditory and olfactory experiences on which he can focus. Put objects in a box and have the child feel and identify them. If the child will permit it, use a blindfold. If he is going to do some smelling, have him put his hands over his eyes. In sum, isolation is a very good tool in sensory and conceptual work with very young children. A lot of useless information more often than not is confusing to the child.

A second thing that you need to know if you are going to work with infants is that you cannot plan in advance a program of activities that you intend to follow. For example, a mother involved in a home intervention project said to the home visitor, "We had to stay up all last night; I knew you were coming and I hadn't worked out the activities all week so we had a crash course."

You need to react to the kind of thing the child is doing. You can't prescribe beforehand. You can bring in the materials--and I will be giving you some examples of some of the areas in which you can work--but you have to "go with the child." This whole concept has been crystallized by J. McV. Hunt into something that he calls "the problem of the match." The problem of the match is finding that activity which is not too difficult for the child and therefore, boring or frustrating, and not too easy for the child and therefore, boring. You must find a particular activity which is just at the appropriate developmental level so that the child will have some difficulty with it, but nevertheless will be able to succeed. It is

impossible to pick out that kind of activity the day before. You have to focus on the child and work with the child until you can find the appropriate activity.

In addition to reacting to what the child is doing, you must guard against the notion of the student as passive and the teacher as active. I have found that it is very difficult to train a teacher to be less verbal. When you are working with a child you will find that you want to fill up the voids of silence with explanation. When you do this, you are not giving the child a chance to respond. You may set the situation up properly, but not pause long enough to give the child the idea that you expect him to respond, let alone the time to think about the particular task. Try not to move the materials around and complicate the situation by verbiage until you are absolutely sure that the child is not going to respond.

Another important thing is what Piaget calls horizontal décalage. If you are trying to teach a child about means-ends relationships by showing him how to get a favorite toy that is out of reach by using a stick, you cannot assume that he has the concept of means-ends relationships once he accomplishes this particular task. He needs to have experiences with pulling strings to get other things, using his foot to reach something he can't reach with his hands. He needs to have many experiences which will broaden his base of understanding; then gradually he will begin to understand the concept. You cannot equate success on one activity with concept understanding. So expand, give lots of different materials and activities for the child in the same areas and at the same levels.

Now for the different areas. The first, and most basic of course, is prehension or grasping skills. All that is necessary is to give the child in his early environment, in his crib or while he is on the floor, things which will alter his grasp. You know that when you tickle the hand of an infant you get an automatic grasping

mechanism. According to Piaget this is one of the basic schemes that people come into the world with. Some of the other schemes that people come into the world with are seeing as opposed to looking, hearing as opposed to listening, sucking, and, some researchers say, crying. Researchers vary in the number of basic schemes they attribute to the newborn, but we do know that there are some basic things that the child comes into the world with. Then he accommodates to the world and changes his ways of behaving as he grows. In relation to grasping, by simply giving the child a variety of objects to grasp, we are altering his original grasping response--with each new object the child must learn a new way of grasping. From here we move toward coordination of grasp, looking and grasping and looking and grasping and sucking. This is a basic part of the evolution of the learning process. All you have to do at the beginning of life is to give infants different things in their environment and they will run through their basic schemes of acting.

The second area would be the area of object permanence. This is probably the most well known area. By object permanence we mean that we are trying to help the infant find out that objects do not disappear when they go out of sight. There are many activities which you can do in relation to object permanence but the basic objective is to help the infant begin to understand that he is permanent, his mother is permanent and objects are permanent. As examples of some of these activities: take a favorite toy and in front of the infant place it under a cloth, hide toys under a table, play peek-a-boo. The activities can get as complex as having four screens and putting your hand under each screen concealing the object that you are hiding. Leave the object under the screens and have the infant search through the various screens to find the object.

A third area which I mentioned previously, is that of means-ends relationships. These activities are designed to help the

infant use tools to extend his action on the environment. Gradually all infants learn that they can use a tool, that they can extend their bodies and their potency in the world. The infant becomes aware that he can extend his capabilities by combining himself with objects or other people. To reiterate some specific tasks: using a stick to obtain a favorite toy that is out of reach; using a string to pull a toy nearer.

The fourth area is that of cause and effect relationships. The distinction between means-ends relationships and cause-and-effect relationships is somewhat less clear than the distinctions between the other areas. In working with cause and effect, we are trying to help the infant learn that there is something within an object which will cause it to do something, or that by acting on an object something will happen. By means-ends, for example, you combine yourself and a hammer in order to drive a nail. By cause and effect, for example, you are trying to understand why a car is moving. Activities which will help infants learn the concept of cause and effect are numerous. You could set up a situation in which a child pushes a ball which hits a stick that falls into water and creates a splash. Using a wind-up toy is another excellent means of demonstrating cause and effect. Wind up a music box and hand it to the child. The child will play with it for awhile, like the music, and then it stops. Usually a very young child's response will be to cry. As he gets a bit older he will hand it back to the person who caused it. Later he will begin to examine the music box to find out what was causing the sound. Still older, he will be able to act on the results of his examination and activate the box again. These cause and effect situations are extremely important experiences to give young children during the first two years of life.

The fifth area is classification. Here we help the infant to develop new schemes, new plans of understanding in relation to

objects. All that is necessary is to give the child soft things, sticky things, pleasant things, fuzzy things, fast things, slow things, big things, small things. Put the thing in front of the child and let him run through his schema. You will see that he will put it in his mouth, rub it on his cheek, crumple it, hand it to somebody. In short, he tries all of the things that he knows. This is his way of learning about things. He runs through all of those actions which help him to categorize aluminum foil as opposed to Scotch tape.

The sixth area is spatial relations. As an obvious example, if an infant is looking at something which is moving away from him he really doesn't know that it is the same object moving farther away. It is a good possibility to the infant that the object is simply getting smaller. As an example, on a recent field trip to an airport one of the children in the 15 to 36 month-old group said clearly that he did not want to go. When they got to the airport the child began to cry. The teacher said, "Oh, it's not going to be that bad or noisy.

We'll be with you and the plane isn't going to frighten you." The child responded, "Yeah, but I can't fit into it. It's only this big." He indicated a very small object. Every plane he had ever seen before was way up in the sky and was only about that big.

Another type of experience comes as the child learns to deal with spatial relationships. In your centers set up cul de sacs, little tunnels, tunnels that are large at one end and smaller at the other so that when a child crawls in he gets stuck. What the child is learning in this latter example is how to judge his body in relationship to other objects in his environment. Roll a ball under a table and have a child crawl under the table to retrieve it. Give the child the experience of having to go around barriers to retrieve toys rather than stopping at the barrier and crying.

The last area, and probably the most important, is the development of imitation. Not only do children identify and imitate their parents, they do this with all adults. We can break imitation into two rough categories. The first would be vocal imitation. You are aware that you can get an infant to imitate your babble. One of the first things that an infant will say is "ah goo." Respond to him, tickle his stomach and say "ah goo" back. Then the important thing is to remain quiet enough to allow the child to respond back to you. This is the beginning of a very basic communication process. Non-vocal imitations are all of those other types of imitation which occur in the child's environment. Again, these can be broken into two categories: visible and invisible imitation. A visible imitation would be, for example, the game of patty cake. It is visible because the infant can see your hands and he can see his hands and he can watch what is happening. An invisible imitation would be doing something that you do which he cannot see himself doing. For example, you pull your ear, and the infant imitates by pulling his ear. Invisible imitations are a little more complex than visible imitations. One of the reasons that children are so fascinated by mirrors is that they have an opportunity to see some of those things that they have never seen before.

After the infant realizes "that's me," it is extremely useful to have mirrors around. You can use them for visual displacements, moving things behind the child.

I would like to conclude with two thoughts. The first is that some of these activities sound very structured. I hope that you will be able to have your caregivers integrate these kinds of activities into the normal day-to-day goings-on in a program rather than to set up a class. This is especially important for programs that work with parents on an out-reach basis or in a center. You should avoid saying, "We are going to have an hour and a half child development class and we will have our formal education for our infants at this time." What you should do is have your parents and teachers involved in the informal learning process that goes on all of the time that the infant is awake. It should become a part of a life style rather than a segmented part of life which you forget about after the hour and a half is over.

The second and concluding point I want to emphasize is the importance of meeting the emotional needs of the infant. Without the warmth, reinforcement, kindness and security that you give to the child he will not be able to explore and learn about his world.

Helping Babies Adjust

BY ANNE WILLIS AND HENRY RICCIUTI

Sensitive caregiving practices may be instrumental in influencing the skills a baby develops for expressing needs, getting attention from adults, and coping with frustrations. Two major areas of concern for people working with babies are coping effectively with distress and helping babies when they are ready to begin learning to guide their own behavior.

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CRYING AND THE RELIEF OF DISTRESS

Understanding crying and distress in order to prevent their unnecessary occurrence and responding to them effectively are major concerns for anyone involved in caring for very young children. Caregivers in a quality day care program for babies should plan and carry out their daily activities with the aim of maximizing the babies' happiness and well-being and minimizing distress. There is relatively little agreement from research evidence on the significance of distress in babies and the best ways of reacting to it. Some studies suggest that responding to a baby's crying by picking the baby up, for instance, will result in an increase in crying over time, whereas if crying episodes are ignored, they will occur less often. Other studies support the alternative conclusion that responding quickly and appropriately to a baby's crying will reduce the frequency of later "fussing." Practitioners--parents, caregivers, and other people who know babies well--also express diverse points of view about distress and its management.

The issue of coping with distress is complex, and the answer is undoubtedly not as clear and obvious as either of the two points of view suggests. It is clear that babies cry for many reasons, and the reasons change as babies get older, making this an area where sensitivity to individual differences is crucial. Caregivers have to work very hard to understand and anticipate distress in order to be even partially successful in reacting to it.

The position taken here is that crying has meaning for the baby, no matter how young. Therefore, a person caring wisely for a baby always responds to crying by noticing it, considering its meaning and how one should react, and then reacting. This does not mean that a good caregiver always intervenes immediately when a baby cries. On the contrary, the caregiver may decide to wait for a time to give the baby an opportunity to quiet himself or herself. Also, a baby may cry, not because anything is wrong physically, but because he or she wants to be held close or played with. The caregiver respects these needs and attends to them as she does needs for food, rest, or dry diapers.

The goal of a parent or caregiver obviously would not be to eliminate crying, for it is one of the baby's first and most important means of communicating with other people. It continues to be an effective way of communicating even after other ways are available. Crying is one of the earliest methods a baby has of exercising some control over the world and learning that people are responsive to his or her initiations. In responding to distress, therefore, the caregiver's goals should be to help the baby learn to trust other people, to know that his or her needs will be met, and that he or she will be responded to and given help and relief when it is needed. At the same time, she wants to encourage the baby to develop his or her own resources in coping with some problems and unpleasant situations.

There are very wide individual differences among babies in the frequency, intensity, and causes of distress episodes. While it can be said that all normal babies cry at

some time and under some circumstances, there are not special cries for special occasions that are typical of all babies. It is true, however, that caregivers can become sensitized to the meaning of particular kinds and intensities of cries in individual babies--that is, whether they indicate hunger, pain, just mild fussiness, or a rather half-hearted attempt to protest, for instance. There are vast differences in the ways babies show distress, just as there is great variability in the way they show pleasure. For example, a fairly mild cry by one baby who seldom gets upset would be more a cause for concern than that same intensity of distress from a baby who is generally more irritable.

Babies also differ widely in their ability to quiet themselves when upset and therefore differ in the amount and kind of intervention they require from caregivers to be consoled when they are upset. Some young babies (less than three to four months old) become excited easily and are generally very "fussy." They may need much direct help in quieting themselves by being picked up, carried, and rocked, or more indirectly, by being cared for in a serene, consistent, predictable setting. Caregivers should not worry about spoiling a young baby by responding quickly to crying, for this responsiveness and help will keep the infant from becoming uncontrollably upset now and will aid in the development of later skills for self-quieting. Some young babies can quiet themselves and should be given the opportunity to do this. The caregiver's response, in any case, depends on her understanding of the individual baby and her perception of the cause for the baby's distress. From the very beginning, the way the caregiver reacts to the baby's crying helps to build a relationship between them.

CAUSES OF DISTRESS

It is unrealistic to try to develop a complete list of causes of babies' crying and appropriate reactions by adults, for individual babies differ, and responses will depend both on the baby and the

situation. As babies become more active, more assertive, develop some understanding of language, and are more mobile, typical causes of distress change. The baby's increasing understanding of the social and physical worlds means that caregivers will react to distress differently when babies are older. There is typically more crying in the early months of life than later, and individual babies may show much more distress during certain periods in their development than others. Young babies may cry at times when there seems to be nothing wrong, and the lack of an apparent reason for distress makes it difficult for the caregiver to respond appropriately. As babies get older, the reasons for crying become more obvious. Instances of crying may become fewer in number but more intense and more sustained.

Some of the most common reasons for distress in very young babies (less than four or five months) are hunger, tiredness, wet or soiled diapers, pain (gas, teething, colic), other discomfort (clothing too tight, too warm, too cool, or an uncomfortable position), boredom (not enough going on around them to engage their interest), overstimulation (too much going on around them), a sudden change (for example, a loud noise, sudden loss of support, bright lights, being placed in a bath, being picked up abruptly). When crying occurs for one of these reasons, the baby should be responded to immediately and appropriately. A caregiver will sometimes have to respond to crying in a trail-and-error fashion, even with a baby she knows well. The caregiver's manner should be gentle and soothing in a deliberate way, for both she and the baby are likely to be feeling impatient with each other and themselves as the caregiver tries to relieve the baby's distress.

The paragraphs which follow contain a more detailed discussion of some of the major sources of distress in the first year of life in a group care setting.

Early frustrations. Around three or four months of age, new causes for distress arise. Not only do babies continue to cry for the same reasons as they did earlier, but as they become increasingly

aware of the world around them, they seem to develop some awareness of their limited repertoire of skills. By this age, babies have the capacity to have modest goals in mind--visually following a moving object, for example. The discrepancy between what they want to do and what they are able to do becomes a source of frustration. A good example of the frustration which may lead to distress occurs in the early stages of reaching, when the baby's aim is not accurate and any efforts are fumbling. After several unsuccessful attempts to obtain an object, some babies seem to become very angry with themselves, and they may cry vigorously. In some of the babies in the Cornell program, it was observed that crying decreased as competencies increased. They became markedly less irritable when they began to creep or crawl well. As babies are able to do more, their frustration decreases, and they are happier. However, as babies become more mobile and take a more active, assertive, adventure-some approach to the world, they are certain to attempt to do many things they cannot do safely, to get themselves into problem situations. New frustrations and at least a few scratches and bumps are inevitable. By giving appropriate help, setting up an environment with as few hazards as possible, and reacting calmly but warmly when the baby gets upset, the adult can help the baby cope with limitations and at the same time learn a curious, investigating attitude toward the world.

Often babies become more impatient and easily upset during a time when they are attaining a new skill such as learning to walk or crawl. Their tolerance for frustration in most areas seems to drop as they direct their efforts toward developing new competencies. At these times, caregivers will want to be especially patient and helpful.

Babies also become distressed very early in life (around three to four months) when something enjoyable is terminated, such as when an adult withdraws attention or an interesting toy is removed. Crying sometimes indicates impatience, also, because needs are not being met fast enough. Learning patience and the realities about the way the world works

can begin early. There needs to be a balance between helping the baby, making the situation easier to cope with or rescuing him or her from it, and letting the baby work things out for himself or herself. For example, a baby who is upset because a toy is out of reach and who cannot move to retrieve it should, of course, have it placed nearer. On the other hand, always accommodating a baby who does not like being put down after being held or who loudly protests the end of the applesauce at lunchtime may encourage excessive crying to get his or her own way or to get attention. A better response to this kind of crying is to distract the baby by engaging his or her attention with something else, by introducing a new toy, for example.

Distress at naptime. This is a common occurrence with some babies. Crying or less intense fussiness and whimpering may be the major cues a particular baby gives to indicate readiness for a nap. If the baby is not asleep when put down in the crib, he or she may cry, perhaps very loudly and intensely, before going to sleep. The infant may be irritated at having been taken away from the action and is tired--ample reasons for crying. If the caregiver is fairly certain that the baby is sleepy, she should leave the baby a while to try to work things out for himself or herself. Since one of the caregiver's goals is to help the baby learn to quiet himself or herself when upset, during this time the caregiver may want to go in, talk softly, and pat the baby. No set time for letting a baby cry at naptime before the caregiver intervenes can be designated, since this depends on the particular baby and the severity of the distress. The caregiver who knows a baby well can tell when the baby has reached the point where he or she will not be able to quiet himself or herself and go to sleep and therefore needs help. This might be as little as five minutes for one baby, or as long as fifteen to twenty minutes for another, particularly if the crying has been only intermittent.

When babies are around nine to twelve months old, the job of getting them to go to sleep may become easier, as the

baby gets used to the routine and seems to accept napping or resting when tired. On the other hand, some babies at this age become less willing to miss what is going on in the room, and taking a nap may become rather difficult. Firm, affectionate, but consistent handling is especially necessary with babies who resist naptime if the sensitive caregiver is to ensure that the baby's needs for rest and sleep are adequately met. The caregiver should not see herself as losing or giving in when she has to help a baby get to sleep or take the baby out of the crib when he or she will not rest.

Unpleasant encounters between babies. As babies begin to move around, opportunities to interact with other babies increase. Many pleasurable play situations occur as babies discover each other. However, there will also be occasions when a baby causes another baby to become upset by exploring the child too roughly or taking a toy, for instance. The caregiver should view these occasions as opportunities to help both babies learn appropriate ways of interacting. Both babies in such a situation need support, sympathy, and redirection. Often separating them is the best solution. A duplicate toy might be introduced if sharing is a problem. The baby who is upset should be comforted, but the goal is to help both babies learn social skills. This might be a good time to introduce a quiet activity, or to put a baby in a crib or playpen with toys for a time to become calm and renew energies.

Fearful responses to strangers. Sometime during the last half of the first year of life, many babies show negative reactions to strangers. This period should be respected, and the baby's feelings should be considered in the day care program. The caregivers should keep in mind the importance of having familiar persons care for the baby each day and provide some protection from exposure to large numbers of people the baby does not know. During the time when the baby is especially sensitive, the caregiver will want to be close, perhaps even holding him or her when a stranger is present. Unfamiliar people viewed from a caregiver's lap are less threatening than

those seen from the floor. Of course, caregivers have to be careful not to be overprotective of babies who are distressed by strangers. If a caregiver runs to hold a baby protectively whenever a stranger enters, and encourages the stranger to stay at a distance from the baby or leave the room, the baby may be learning that new people are to be feared. Rather, through their relationship of trust, the caregiver is in an excellent position to help the baby begin to react positively to new people.

Excessive confusion and change. Crying may both contribute to and reflect the atmosphere a baby is in. One cause of crying to be guarded against in group care centers relates to the overall atmosphere in the room--the noise level, the amount of activity, the calmness or confusion. As previously mentioned, some babies are much more capable than others of filtering out distractions and unnecessary sights and sounds impinging on them. More sensitive babies, who are less able to "turn off" distractions, become very upset when there are too many things happening around them. Planners of physical space and equipment as well as activities for babies must think about ensuring some calmness and serenity in the day. Babies who become upset because too much is going on need to be redirected to quieter, less exciting activities.

It is expected that babies may cry more than they usually do as they adjust to being in a new environment with new caregivers. This would also be true after a long time away from the day care program. After a few days, if a baby continues to show a great deal of distress and the caregivers cannot help, perhaps the parents should be consulted about what could be done to make the day care experience more pleasurable.

Many common causes of distress have been discussed. However, there remain, even for the experienced caregiver, occasions when both the cause of distress and the appropriate response elude her completely, and she attributes it to the weather or some change of routine. Often the cause of general crankiness becomes obvious a few days later, when the baby develops a

cold, ear infection, or some other illness. Here, too, parents and caregivers can be helpful to each other in looking for explanations.

RESPONDING TO DISTRESS

There has been some discussion already of the ways caregivers may react to babies' distress. There are two additional, broader issues relevant to responding to distress: the appropriateness of giving and withholding attention in certain situations and how that affects the baby's use of distress to get attention; and secondly, the importance of giving babies some opportunities to learn to quiet themselves.

The importance of a great deal of individualized, personal attention for babies' development and general well-being is stressed throughout this book. While caregivers in a group setting will have many demands on their time and energy, they must guard against giving babies attention only when they cry. They should, rather, respond to positive social approaches and attempts to communicate by the babies. It was stated earlier that very young babies cannot be readily spoiled; that is, reacting quickly and perceptively to their distress will help them learn to use their own resources later. As babies get older, however, caregivers want to avoid communicating to them that the most effective way of getting attention is to cry. Many people disagree about when babies begin to use crying in a deliberate way to get something they want. Whether or not they use distress in this way before the end of the first year is debatable. It is clear, however, that a baby may learn very early in life that crying is a good way of attracting an adult's attention. If the baby is not sufficiently rewarded for more positive attempts to communicate (being picked up when holding out arms, being smiled at when smiling, for example), the baby may learn to rely primarily on distress to get attention (behavior many people would regard as characteristic of the spoiled baby). It is also true that some babies seem to want more attention than a caregiver can possibly give. On occasions when the caregiver

feels that the needs of these babies have been met, including needs for individual attention in the form of social interaction and play, the caregiver might decide to ignore distress and see if its frequency decreases over time. With these babies, cooperation between parents and day care staff is imperative if changes in the use of crying are to be made.

In thinking about when and how she should respond to distress, the caregiver must keep in mind the importance of both giving attention and support to the baby, as well as helping the baby develop the ability to quiet himself or herself. Babies need to learn to tolerate frustration and work out minor irritations on their own. It is difficult but wise for a caregiver to respond by doing and saying nothing when a baby is complaining over a small problem that she thinks the baby has the competence to work out on his own. Allowing the baby to do this is one way a caregiver provides appropriate challenges that lead babies to develop new competencies and skills.

The ability to quiet themselves when they are distressed is a dimension on which babies vary widely. Some babies, even if they become very distressed, seem to be able to calm themselves relatively easily after a period of being upset. They come out of these periods quickly and get involved easily in an activity. Other babies, when they get upset, seem to have to "cry themselves out," and their periods of distress become more intense and more sustained than those of the other group of babies unless they are helped by an adult to quiet themselves. For some babies, the caregiver may only need to say a few comforting words at a distance, while with another baby in the same situation she knows that she will have to go over, pick the baby up, and help him or her more actively to get over the crying.

In responding to distress, the caregiver looks first at the immediate situation for a cause. For example, maybe the baby is bored with the toys available, perhaps is in an uncomfortable position, may have been bothered by another baby, or perhaps has had a toy taken away. These are situations that can be cor-

rected easily. If there is no obvious reason in the immediate situation for the crying, the caregiver will think about the baby's schedule and look for signs that he or she is sleepy, hungry, or needs a diaper change. If the fussiness is still unexplained, the caregiver thinks back to the mother's report and the day's observations to decide if the baby is teething or is reacting to medication or an injection or may be catching a cold or other infection. Then the caregiver may consider the possibility of a change in routine at home or in the nursery that could be upsetting, such as a parent or caregiver being away or a stranger's presence in the room.

Probably the most common (and most successful) responses to distress are functional ones--feeding a hungry baby, diapering a wet one, giving an interesting toy to a baby who is bored. At other times the caregiver first has to calm the baby, to help stop the crying by holding, singing, or talking quietly to the baby. Sometimes the most soothing response for a baby who is in pain or ill or whose distress is of uncertain origin is holding him or her and rocking or walking, and singing or talking gently to the baby. Being comforted this way tells the baby he or she is cared about, and it may take his or her attention off the unhappiness for a time. Older babies can appreciate verbal reactions to distress better than can younger ones. Often a caregiver can quiet an older baby just by talking to the baby across the room, whereas younger babies need to be picked up or patted, as well. The caregiver's reaction should match the distress--that is, an occasion when a baby is really hurt or upset is not the time to give the baby the chance to quiet himself or herself.

In a group program, the prevention of distress should be as much a concern as coping with distress when it happens. A fussy baby contributes to an unpleasant, often tense atmosphere for other babies and caregivers, and can cause more distress. The best strategy for preventing distress and keeping it at a minimal level is to anticipate needs before they

occur by knowing the babies' schedule and being alert to early signs of hunger, sleepiness, or irritability. Several other guidelines for minimizing distress relate to points made in other sections of the book.

1. Set up a safe, interesting environment that is not overly stimulating or too restricting.
2. Help babies learn to have pleasurable interactions with each other by protecting them from hurting each other as they begin to interact.
3. Provide many opportunities for success.
4. Give babies encouragement and help.

A wise general policy is for caregivers to minimize occasions likely to produce distress in the day-to-day operation of the program.

Many potentially distressful situations can be avoided by a sensitive caregiver who knows the baby's limitations and who does not see the baby's distress behavior as a deliberate effort to test her or make unreasonable demands. For instance, a baby who in the caregiver's judgment should not be hungry may get very upset if he or she has to stand by while another baby is being fed. A perceptive caregiver, rather than ignoring the problem or punishing the baby for being unreasonable, will help make the situation easier to tolerate. She might help the baby get interested in another activity or allow him or her to participate by eating a cracker or a piece of fruit while the other baby is being fed.

Most people who care for babies will agree that coping with distress is one of the most challenging issues they face, partially because of the obtrusiveness of crying. A baby's crying tends to affect negatively anyone who can hear it. A period of prolonged fussiness and crying will wear down even the most patient and understanding caregiver. At such times, having another caregiver take over for

a while may be very helpful. Caregivers may have to be reminded that anger is always an inappropriate response to crying. Punishing a baby for crying will serve no constructive purpose and may be harmful. A caregiver working with an irritable baby who will not be quieted needs support and relief from other caregiver, for these times are perhaps the most difficult aspect of caregiving.

In general, having reasonable expectations and gearing the daily experiences to each baby's developmental level and style will minimize unnecessary distress and create a much happier setting for adults and babies. Coping with frustration and learning to tolerate delays and disappointments are challenges which sometimes lead to distress. The caregiver's role in reacting to babies' distress comes from a concern for making the baby's experience as pleasant as possible, but at the same time challenging the baby to develop his or her own resources.

Developing a Meaningful Toddler Program

BY SALLY GOLDBERG

The great need for more toddler centers, is a recent and growing concern of pre-school educators across the country. To help crystallize our thinking, toddler is defined as a child between the ages of 16 mos. and 3 years. Our imagination should immediately conjure up a picture of a group of delightful 1's and 2's, who seem to be all over the room, never seem to slow down physically, tire easily of things, are impatient with people, are babies and at the same time growing inde-

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pendent, need lots of attention and nurturing love, but yet can easily be smothered by too much structure and not enough opportunities for self discovery.

Our next concern then would be to program wisely and have an adequate facility and sufficient equipment for the toddler age group in order to best meet their needs.

MEETING THE TODDLER'S DEVELOPMENTAL NEEDS

Physical Characteristics

1's - The child after the first birthday has probably tripled his body weight. He uses finger and thumb to pick up things. His eyes work together and his teeth appear. He drinks from a cup and attempts to feed himself. He generally walks with feet apart and body forward for balance.

2's - The child here has slowed down in physical growth. He runs, climbs, pushes, pulls, lugs, climbs stairs one at

a time. He feeds himself, can undress himself, and is usually toilet trained for most of the day.

Personal Characteristics

1's - The toddler speaks a few simple words but is adding rapidly to his vocabulary. He speaks words and short sentences. He can play alone for short periods. He likes to explore his own body. He enjoys taking objects in and out of other objects.

2's - The child likes consistency. He gets upset if his mother leaves, but usually quickly calms down. He's very active, but wants to be independent. He is balky, and may quickly change his mind. He shows flashes of temper and changes of mood. The toddler may have one favorite food and want to eat only that food. A toddler imitates adult activities, but finds it hard to share. He loves water play and everything messy. A toddler demands constant attention, and understands more than he can verbally express.

How We Can Help a Toddler's Growth

1's - Don't use baby talk. Let the child handle and explore things. Put dangerous objects out of reach. The child should be carefully watched and guided (not guarded). The child should be educated in self-protection. Furniture should be the correct size so the toddler can touch the floor and have good back support. A toddler needs to go outside to play and be taken for walks and rides.

2's - Maintain a daily routine and try to keep it as consistent as possible. Encourage but don't hurry or interfere with the toddler. The child needs affection, and maybe even a bit of "babying." Try to avoid a lot of "no's" and give him some alternatives. Avoid long explanations to a 2 yr. old. Remember how important an adult example really is.

PROGRAM ACTIVITIES

Body Expression and Control

1. Work with small objects of various

sizes, shapes, and textures.

2. Draw on grocery bags, newspaper ad sections, cardboard, or wrapping paper on floor or table.
3. Pile lightweight blocks up on top of one another for tower building.
4. Climb through, under, between objects. Climb stairs or climber/slide.
5. Use active large muscle equipment such as trikes, tunnels, balance beam, and sand box.
6. Pound with hammer.
7. Pull musical toys.
8. Activities so toddler can hop, jump, run, lug, push, and pull.
9. Dress and feed self.
10. Turn pages of book.
11. Paint with fingerpaint, colored water, fruit, vegetables, hair rollers, pine cones, and sponges.
12. Paste with cereal, macaroni, popcorn, beans, paper, wallpaper, cardboard, tissue paper, and fabric.
13. Work puzzles.
14. Blow bubbles with drinking straws in colored water.
15. String beads, buttons, macaroni, foam pieces, thread spools, or pieces of drinking straws.
16. Use everyday mechanical things as locks, screw caps, keys, buttons, zippers, snaps, nuts, and bolts.
17. Set actions to music.

Social Play

1. Play pat-a-cake and peek-a-boo.
2. Roll ball to others.
3. Play pretend games.
4. Ask child about himself (hair, features, clothes, shoes, toys).
5. Give simple tasks and then praise for doing them.
6. Give opportunity to imitate adult activities (play broom, dustcloth, mop, wash table, help cook and bake).
7. Let dress and feed self.
8. Help clean up own mess and be responsible for toys.
9. Provide mirror and dress-up clothes.
10. Play "I am a Mirror," and "Follow the Leader" type games.
11. Help choose clothes for the day.
12. Brush teeth after lunch and wash hands frequently.
13. Opportunity to play in small groups

(3 to 6) or in larger groups (no more than 12 if possible).

14. Play with puppets and mirror.

Thinking

1. Unwrap, and unscrew objects.
2. Allow opportunity to combine small objects with larger ones.
3. Match clothes, sizes, cups, spoons, dishes, glasses, toys, shapes.
4. Identify animals, household objects, environmental objects.
5. Count plastic silverware or poker chips.
6. Put clothespins inside container.
7. Nest measuring cups inside one another.
8. Use feltboard for grouping and counting.
9. Imitate a cube block, button or poker chip design.
10. Match sounds with sound boxes.
11. Play with faucets, doorknobs, keys, locks, etc. mounted on wood.
12. Roll marbles down an incline.
13. Pour colored water into various sized containers.
14. Make a feeling box or bag and guess objects inside without looking.
15. Imitate sounds and actions of leader.
16. Take time for "pretend" games.

Language

1. Use words to label objects you use or things you do.
2. Talk about relationship ideas (in, out, over, under, on top, bottom, with, without).
3. Count aloud (fingers, toes, blocks, buttons, thread spools).
4. Demonstrate meanings of words (loud, soft).
5. Play singing games.
6. Do finger plays.
7. Read lots of books.
8. Play records and sing songs.
9. Let him run simple errands (put towel in basket, book on shelf).
10. Teach him to follow directions.
11. Help child develop words for actions, people, objects, and expressive feelings.
12. Dramatize stories in books through role playing or puppetry.

13. Tape child's voice and let him listen to self.
14. Tell stories about himself and his family, and his immediate surroundings.

Emotions

1. Be sure child has place of his own for belongings.
2. Be affectionate.
3. Be low-keyed in voice and action.
4. Give child a chance to be angry, but express anger in an acceptable way without hurting others.
5. Let child be independent when possible.
6. Let child say no when it is possible.
7. Give child choices whenever possible (toys, clothes, trips).
8. Give child variety of foods, toys, and experiences.
9. Give child things he can be successful with and encourage him frequently.
10. Help child establish sense of himself.
11. Teach child to laugh at himself.
12. Take pictures of child and let him enjoy seeing himself and his friends at preschool.

APPROPRIATE TOYS, MATERIALS AND EQUIPMENT

A center for toddlers needs appropriate toys, equipment, and furnishings.

Tables and chairs should be washable, durable, and correct size to enable child to touch floor and have proper back support. Cots, if needed for nap-time, should be sturdy, 6" off the floor, and washable. Shelves should be open, and no more than 4' high so the child can reach materials himself. Individual spaces for outer clothing should be of correct height, so child can hang up his own clothes. An adult rocking chair and a child-sized rocker is pretty much a "must."

For large muscle play, there should be an appropriate sized wooden climber and slide combination, and/or one of those

large plastic snap wall climbers. A balance beam and rocking boat that turns over into stairs are excellent. The toddler needs things to ride on, a low tricycle, scooter toys or large trucks or trains. A wagon or doll buggy to get into, a hobby horse to ride, or Johnny Jump animals to bounce on are all good. Balls should be large and soft. Sand can be used indoors or outdoors with lots of plastic accessories.

Dramatic play is very important at this age. Appropriate equipment would be a sturdy, wooden stove, refrigerator, hutch, and sink, preferably without doors, and with lots of accessories like sturdy pots and pans, dishes, and fruit. No dramatic play area would be complete without dress-up clothes, particularly hats, purses, low-heeled shoes, vests, and uniform tops, a small-sized broom, dust-pan, and mop set, 2 wooden telephones, and a doll crib, bed, or cradle with 2 large baby dolls.

Sensory stimulation is important at this age, and a good sand/water/bean table or tub activity is a favorite. Be sure to include flannel backed plastic aprons for this activity.

Cognitive toys should include lots of solid wooden and plastic materials teaching shape, color, and size.

Manipulative toys should include many colorful plastic, put-together toys, and lots of puzzles with knobs on top about everyday life, made up of 4, 6, or 8 pieces.

Art should include a full range of paint, paste, playdough, large brushes, easel, and larger paper.

The block corner should include plastic, cardboard, or foam blocks, and a shelf to store and sort them on. Accessories such as wooden people, animals, cars, boats, trains, planes, ramps, and road signs are very important.

Music can be primarily through the piano, phonograph, or cassette, with lots of help from tambourines, bells, rhythm sticks, drums, and the most important, the voice!

Book corner can include easy shelf access to books, cardboard and cloth books, bean bag chairs, vinyl pillows, and a cozy rug.

Don't neglect the science corner with a simple clock, calendar, scale, magnets, prism, measuring cups, measuring spoons, and room thermometer.

Everything should be safe, sturdy, and scrubbable, and kept clean to minimize the spread of contagious diseases.

III staff development

Training Caregivers to Provide Loving, Learning Experiences for Babies

BY ALICE HONIG, Ph.D.

A sense of the urgent importance of training for infant caregivers may perhaps be better realized if we keep in mind 1) some recent historical trends, 2) evidence from infancy research, and 3) theoretical ideas about the nature of optimal infant development. Such a triple perspective can also provide us with clear ideas about what a training program needs to include: the "how to," "what to" and "when to" that a caregiver needs to know in order to provide developmental, enriching, loving and learning experiences for babies. In addition to those perspectives, a realization of the fundamental and preeminent role that parents play in the development

of a child's happiness and competence in all areas must permeate any kind of training effort. Thus, a training program will need to include methods of communicating comfortably with parents to share information and skills.

During the past decade, the need for a variety of settings to supply developmental--as opposed to custodial--care for babies has been highlighted by a sharp increase in the number of young unwed mothers who want to return to complete their schooling, and an increase in working mothers with children under three years of age. Also during this time period, public schools have been accumulating evidence that in not all families are children equally well helped to gain social and language skills and cognitive

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understandings needed to become ready for early school experiences. We have begun to understand that quality day care, a developmental boost for babies, is something all of us parents and providers alike need to know more about.

Fortunately, during this same time period, infant researchers have continued to fill out a picture of what kinds of adult social responses, cognitive transactions, and language exchanges with infants are most likely to be associated with later child competence, good feelings about self, successful problem solving, and a rich, expressive play and language repertoire.

Theorists, too, have provided much help. We shall all be grateful to the three babies in papa Piaget's family for their delightful and vigorous participation in their famous father's ingenious games with them. The games that Piaget devised for his babies illuminated the wide range of understandings and abilities in the sensorimotor period. Piaget revealed the subtle details and coherent, sequential patterning inherent in the growth of an infant's understanding of how the world is organized and how things and persons behave. Whether a baby creeping about the livingroom floor takes an interested bite of his teething ring or of the family cat is likely to lead to radically different consequences and learning! Piaget has taught us that the baby learns by constantly acting upon and interacting with his world. Encounters with people, places, and objects encourage new learning, when they are not too puzzling or difficult, nor too easy or too well known. A slightly new situation or problem will be most highly motivating. If an infant can pick up soft, cooked carrot cubes from her high chair tray, then cooked, wiggly spaghetti strands should be a refreshing, but not insurmountable, challenge. Piaget has given us cogent reasons why we need to match our responses and offerings to a baby's level of ability and understanding.

Piagetian theory further suggests that the richer and more varied the opportunities for interactions with the physical and social world, the greater are a child's

chances to accomplish the developmental tasks of the first few years. What are some of these developmental tasks that caregivers need to know about in training sessions? How can a caregiver help a baby accomplish these developmental tasks with pleasure and success?

PREHENSION SKILLS INCREASED

If a colorful, safe toy is dangled over a crib within reach of an infant's hands, swiping, reaching, and grasping will more likely be practiced. Provide toys of varying shapes and sizes that baby can transfer from hand to hand, squeeze, poke, pull, handle, and shake; as well as safe, nutritious tidbits that he can grasp and chew. You may be rewarded at the end of the first year of life by seeing baby victoriously and competently pluck birthday cake crumbs from his lap, using just his thumb and forefinger in a precise pincer grasp! Provide toys that allow a baby to "hold and operate." One hand can steady the paper, while the other hand scribbles. One hand can hold the hammering bench, while the other hand pounds in a peg.

INTERCOORDINATIONS PRACTICED

Babies need practice in coordinating information they receive from different sources. They also need practice in coordinating their actions with respect to one another. Baby will turn to search with his eyes for the sound of your voice. That which is heard can also be seen. Information about a loved adult can be obtained through the eyes, as well as through the ears, as well as through the ears and other sensory systems. Watch a seven-month-old infant trying to bring a cup with milk in it to her mouth. She reaches, grasps the cup, and slowly moves the cup in a trajectory toward herself. Alas, sometimes the information received back from eye and arm muscles is not coordinated, and the little hand continues past the ear carrying the much desired cup right out of sight.

How many adults carrying around a baby have been startled to find their arm being tenderly licked? A baby learns about the world by acting on it in all possible ways. Place something familiar and delectable, such as a teething biscuit, about a foot in front of an eight-month-old as he lies on his tummy. He may well try to grasp what he sees. Put something in his hand, and he may well try to bring the hand up so he can see what he is grasping.

OBJECTS ARE PERMANENT

The beloved game of peek-a-boo (as well as other games such as the search for objects which a caregiver has hidden under pillows, or cups, or behind other toys) helps the baby learn that the world is a stable place. Out-of-sight toys can be found. Out-of-sight people, to whom a baby is attached, can be counted on to reappear. Ainsworth and Bell (1972), incidentally, have shown that mothers who spend a lot of time with their babies in warm, responsive interactions, who are sensitive to their baby's signals, and who also give babies "freedom of the floor" to explore, have babies advanced in developing the concept of object permanence, no matter what the socioeconomic circumstances of the families are. Quality infant caregiving seems to help "inoculate" a baby against developmental deficits sometimes associated with child rearing in poverty households.

INTENTIONALITY INCREASED

Babies learn more and more that sometimes we have to carry out one action in order to be able to do another. A toddler may learn that in order to "snitch" a cookie, she has to stand on a chair so that she can reach the counter and cookie jar. Many toddlers enjoy learning to turn a light switch or a television knob, in order to bring about interesting visual or auditory results. Baby bangs with a stick to get a xylophone to make musical noises.

CAUSE & EFFECT DISCOVERED

Adults who provide toys that do something when baby acts upon the toys can provide opportunities for babies to discover the relations between causes and consequences, between goals and the means of achieving them. Such toys need not be fancy. A long piece of thick knitting yarn, tied to a favorite toy, provides a challenging problem in using the string in order to reach the toy. Providing a spoon for baby to use during feeding times allows explorations of ways and means to keep enough food in the bowl of the spoon until it reaches the mouth, so one actually gets a taste.

A caregiver who comforts a distressed baby helps the baby to learn "if-then" causal relationships: "If I cry, something happens." "If I am upset, someone comforts me."

SPATIAL RELATIONSHIPS LEARNED

Babies whose crib positions are changed from time to time, and who are placed on their tummies on warm floors to try their own methods of exploring space, will have a better chance to learn about the unders and overs, the ups and downs and arounds, the nears and fars, of space. The infant who drops and throws things from his high chair tray, then peers intently to see where they went, may not simply be out to aggravate a busy caregiver. As well as practicing voluntary hand release skills, baby may be teaching himself all kinds of interesting things about how space is organized. Roll a large colorful ball under a sofa, a rocking chair, or a low table. Baby may crawl around the "barrier" to retrieve her ball, thus advancing her learning that space is continuous and that there are several paths to the same goal. Give a baby a link chain and an empty margarine tub. Watch him try to get the long chain into the container. Does he feed the links in one by one? Does he dangle the chain down into the tub? Or, more maturely, does he bunch or roll up the chain in advance, before dumping it successfully into the tub?

Simple household items such as pots and pans and measuring cups, when made available to babies, can help them discover the relations between container and contained, between narrower and wider spaces.

LEARNING TO IMITATE

When they are learning to imitate gestures, babies seem to follow a rather regular progression. Familiar, visible gestures are easiest; unfamiliar, invisible gestures are hardest. That is why pat-a-cake games are so popular, from the times babies have learned on their own to bring their hands together at the body midline. Imitation is hardest when the model an adult provides is unseen and unfamiliar. Holding a young baby up to a mirror, while you play a game of "touch your nose" or "touch your eye", will make this imitation game easier for him.

ACTION REPERTOIRE GROWS

Babies find out about new objects in their world first by applying all their well-rehearsed skills--or to use Piaget's term--schemas. They taste, lick, wave, stroke, poke, bang. Yet new events and toys have their own characteristics that demand a baby's attention and his interest, and demand new ways of dealing with, acting upon, or adapting to them. You can not pick up a cooked, green pea with the same hand grasp that gets you a toy block to be chewed. A cup can be bitten or waved, but also used to get a drink. Pop-it beads can be pushed and pulled, but they can also be used as a necklace to adorn one's self. Blocks can be used to bang with, but also to fill a container or to stack vertically into towers, or horizontally into "choo-choos."

Training should help sensitive caregivers see new opportunities inherent in a variety of toys and experiences. Training helps us stay aware of experiences that may be so difficult that they both help enlarge a baby's repertoire and often prove frustrating and confusing.

COGNITIVE SKILLS IMPROVED

A baby who cries when her mother or father or a favorite caregiver leaves the room, but not when a stranger leaves, has formed a primitive sort of classification system: "people to whom I am attached" versus "other persons." So has the baby who turns her face away when the caregiver's hand approaches with a teaspoon of strained liver or with a wash cloth, but turns eagerly toward that hand when it approaches with a spoonful of applesauce. As an infant grows out of the sensorimotor and into the preoperational period, where she is capable of mental representation, she progresses to more complicated classifications. Ask an older toddler to put his toys where they belong before bed time. He may well know that all the stuffed animals go to sleep in one corner and all his trucks and cars and fire engines go into their cardboard box "garage" for the night.

With regard to polar concepts, or opposites, toddlers learn early to ask for "more" cookie, although they may only exhibit understanding of the concept "less" at the gut level, which impels an indignant howl if an older sibling, for example, gets lots more ice cream in her dish than the toddler. Provision of many opportunities to understand opposites is important. Wet washcloths and dry ones, soft cheeks or sponges compared to hard blocks or heads--these materials and experiences allow the caregiver to help baby formulate an idea of the attributes of objects and of people, too, as in "happy" and "sad" or "cold hands" and "warm hands." Ultimately, the toddler's ability to deal with finer and finer gradations of attributes will lead to the ability of the preschooler to seriate--that is, to order objects according to dimensions such as length or width or loudness or heaviness. Some infants enjoy a simple seriation activity which involves nesting and stacking three different sized orange juice cans. Some toddlers can line up the family shoes or boots according to size, from the littlest to the "more bigger", toddlers say.

LANGUAGE LEARNED

Language gives power. Language helps us get someone to meet our needs: "Shoe on"; "More juice"; "Go bye-bye car, daddy!" Language provides aesthetic play and pleasure as in early baby-invented rhymes: "Oogy, poogy, woogy bear!" Training needs to teach us about the ways in which the comprehension, expression, and production aspects of language develop. Babies coo in open vowel sounds, then use easy consonants to create "da-da" and "ma-ma," to the unutterable pleasure of their parents who endow these first combinations with loving significance. Later on come the long strings of jargon, those babbles out of which first single words and then two-word phrases, and later more complicated expressions arise.

Providers can use four useful principles to promote infant language development. One is the principle of the match which was discussed earlier. Caregivers who want to encourage a baby's sociable babbling would do well occasionally to imitate baby's own "ba-ba" or "guh-guh" sounds. Babies who hear their own sounds back often give a caregiver a surprised, delighted look that seems to say, "Hey! You speak my language. Wonderful." Of course, some sounds are really hard to imitate, as the "dlth" a four-month-old once offered me as I tried talking games with him. Familiar sounds are the easiest for a baby to copy and say back to us. Training helps us learn what sounds are easier, which tend to appear earlier, which are harder (as the "r" in water), what the progressions are in the development of certain constructions, such as the progression from "No I bite her" to "No, I did not bite her."

If the baby is not yet producing consonants, sensitivity to the problem of the match will help us to listen for the open vowel sounds the baby does use and to say these back to him. The earnestness with which a four-month-old can carry on a conversation in his language with an attentive adult is a sight to behold. In Dr. Bettye Caldwell's (1967) film "How Babies Learn" (an excellent training film for an infant program), there is a delightful sequence of such an animated conversation

between baby and caregiver.

The second principle is to be consistent in responding to the infant's vocalizations and verbalizations. When baby uses language, reward her by talking back to her promptly. Home observations by Yarow, Rubenstein and Pederson (1971) revealed intriguing evidence that when baby vocalizations were responded to (contingently) by mothers, the babies vocalized more to a toy presented to them.

The third principle is to talk about what the infant is looking at, feeling, listening to, or doing. "You are eating your meat." "Darren is putting all his blocks in the pail." "Suzie, you are hugging your doll so gently." Sensitivity to the problem of the match helps us to modify our words appropriately with infants. We would not particularly say "Darren, what interesting atonal music you are composing with your xylophone!" But we might say "Darren goes la, la, la," and sing the notes so that they give the baby an idea that what he is doing has a name. It is rewarding to watch how quickly an infant learns new words for what he is doing. A while later if you come over and ask Darren to "make la, la, la" again, he may pick up his xylophone stick and promptly comply.

The fourth principle is to talk about what you are doing as you work or play near, or for, or with a baby. "I'm mashing banana for your lunch," "I'm tying your shoe," "We are putting away our blocks all nice and neat on the shelf." Diapering, bathing, and feeding times are ideal one-to-one lesson times for language, for sharing joyous experiences in the context of a loving relationship, whether the caregiver is providing comfort to bottom or top of baby. Yet how sad it is to visit care situations where one stands near a diapering table for half an hour to hear only silence, and watch eyes riveted only on bottoms. Training sessions should include a good bit of role playing--sessions where providers can learn to diaper and also to teach, for example, "tummy" and "toes" and a host of other words. Large dolls can be used, if necessary, for this practice.

LARGE MUSCLE SKILLS DEVELOPED

When they are not cooped up for long periods daily, babies spend a lot of time energetically learning to use large muscles in gradually more coordinated, graceful, and effective ways: to creep, to walk, to run, to rock, to bounce, to crouch, to dance, to jump, to tumble, to slither, and to slide. We need to provide sturdy furniture and large floor spaces for such accomplishments. We do not need to "walk" a reluctant or terrified, crying baby around a playroom to promote walking, as I have watched well-meaning caregivers do. Many times the best kind of help a provider can give is to arrange things well for a baby to make discoveries and ventures on his own.

FINER SKILLS LEARNED

Babies need to learn to listen to stories, to leaves blowing in the wind, to music, and to people talking. They need to feel textures, of clothing, of walls, of foods, of toys. They need to explore new tastes, to sniff flowers and bread baking. It is up to the caregiver to provide sounds, sights, smells, and tastes in judicious doses, at appropriate times. We must always be careful not to overload baby's sensory world. Babies who live in a sensory-overload world of a very quarrelsome household and a constantly blaring T.V. sometimes protect themselves by tuning out sensory experiences.

EMOTIONAL LEARNING INTEGRATED

Intertwining with, and profoundly important to, the successful outcomes of the dozen developmental tasks noted above is the central task of developing into a wholesome human being. The social-emotional task of the infant is to develop into a person capable of relating to people, to work, and to the world with genuine friendliness, zest, interest, and purposefulness. Emotional learning is indivisible

with, and totally integrated with, other developmental tasks. Helping infants and toddlers develop into wholesome caring persons is of the highest priority for providers.

Erikson's theory of the stages of social-emotional development and the conflicts and resolutions of each stage places the development of trust (as opposed to mistrust) as the basic emotional learning task of the first year of life.

Adults who trust themselves to be loving and facilitative and are sensitive to the infant's signals and responsive to his expressed needs nurture that infant's trust in adults, as well as in his own ability to express his needs and to get someone to meet his needs. Trust is built on a four way signal system. The curriculum of an infant care setting can advance an infant's development only if all those "signals" are "go."

If a baby enters day care with tenuous or damaged trust in adults about his own capacities to have his needs met or to explore the world safely then the "curriculum" for the first few months may consist of innumerable caregiving and loving acts by which the adults build that basic trust. As Lally (1970) has put it: "If a child does not feel secure, he will not learn . . . (Adults) must make themselves available to the children as a source from which children can explore the world."

Erikson characterizes the nuclear conflict of the toddler stage as centering around the development of autonomy versus shame and doubt. Thus, loving protectiveness is not enough. The toddler must have myriad opportunities for exploring the world, taking things apart, asking unexpected questions, and making messes once in a while. Such opportunities allow the child to find his own strengths and competencies, to feel self-reliant and self-satisfied. Such freedoms, structured with safety, nourish in 2- and 3-year-olds a sense of autonomy and initiative. (Honig, 1974).

In an infant care setting, cognitive and

emotional supports are inseparable partners. Adults must provide both to help babies thrive.

TRAINING INCLUDES PRACTICE

Training should provide practice with real live babies for providers who have not yet begun to work with infants. Learning to meet the problem of the match in offering activities to babies, or in responding to their actions, takes sharp observation skills, a high degree of patience, much ingenuity, and lots of practice.

Opportunities are needed to practice caregiving routines, while at the same time providing language lessons and promoting loving trust. Training should help us to integrate experiences. The ability to embed curricular offerings within the context of a loving relationship and within the framework of daily routines is vital to ensuring naturalness and workableness to an infant curriculum. Enriching activities for babies can be easily embedded in the daily round of activities carried out with the babies.

Practice with babies also helps a provider to become sensitive to the different styles and temperaments of different babies. Some infants need and love adult urging and attention during a task. Some need and prefer to try things more on their own with fewer adult comments or interferences. For example, I once asked a toddler to fill all the holes in a peg-board with colorful pegs after I had made sure that she could easily place and remove just one peg. She gave me a look from under lowered lids which led to a hunch that she did not care for a hovering adult while she worked. So I pretended to be busy writing notes as she worked. She set to work purposefully and seemed to relax when left to complete the task at her own pace. When she had finished, she very happily accepted my praise as I looked up to find all the pegs correctly placed in the board. Still, another baby may seem to need all the reassurance and encouragement we can give in order to stay on task and to persist at a difficult job. Some babies

want applause and verbal praise for each peg placed and also reassurance that they are proceeding all right. Babies differ very much in their learning styles.

Training plus practice with babies can help us become aware of these different styles and tempos among infants and adults. Some of us eat very slowly; some of us talk in a rush. What is the style of each of your babies? What is your style with each of your babies?

Some babies prefer a quieter adult voice, a gentler touch; some enjoy the rough-and-tumble vigor of another provider's style of handling. All babies need some stroking and loving and bodily contact. Our bodies are an important part of an infant program. Most of us have read about Harlow's (Harlow & Zimmerman, 1959) experiments with infant monkeys. Cuddly contact comfort with a cloth mother turned out to be vitally important for an infant monkey's mental health. Cloth mothers who did not provide milk were still clung to affectionately and used for comfort and reassurance, whereas wire mothers who supplied milk were treated by the infant monkeys strictly as a food source, not as a source of love. Physical loving pats and strokes nourish the self-love of a baby. Erikson has taught us that only as we are given to by others do we learn how to be givers ourselves.

Practice with babies should help a provider realize how often, and in how many different ways, a baby may need to discover the same idea on his own, or be told or shown something new, before learning-that-sticks occurs. Many caregivers forget this simple fact of learning when, for example, toilet training is concerned. Also, a caregiver may feel sure that a baby can solve a certain problem "just fine." But things we have tried and just barely succeeded at on one occasion need more time and practice for skills to become consolidated. Learning requires practice and adult patience. Learning also requires that the caregiver provide varieties of opportunities in many different conditions and settings for a baby to learn thoroughly. A baby may have learned to say "please" when mother holds out a cookie invitingly and scans her

baby's face for the polite work she is teaching. Mother should not be shocked or angry if baby does not at first remember this new rule for a new person such as a visiting relative.

Another example lies in the subtle ways we may or may not teach babies about the importance of language in all activities. For example, do we mostly talk with toddlers when they are playing in a fine-muscle area with puzzles and such toys? Do we rarely use language in an open play space, where babies climb and slide? Is the labeling of pictures done only in a reading corner or do we also point out "STOP" signs and other signs when we take toddlers on a walk outdoors? Do we also talk about and label the pictures that decorate our infant room? Broadening the variety of settings in which babies have cognitive and language interactions with caregivers plus helping parents to carry out and enjoy such interactions with their infants will promote the carryover of new learnings into many life situations.

Practice with live babies should sharpen our understanding that a variety of tactics, as well as settings, may be necessary in order to find one that works with a particular baby. For example, at the Syracuse University Children's Center, one two-and-one-half-year-old lagged markedly in language production compared to his peers. Adult pressure for the toddler to talk was not the answer. It did take ingenuity to discover ways to elicit language. One day his perceptive teacher watched Tommy's untied sneaker fall down to the ground as Tommy climbed the geodesic dome in the large-muscle area. "Oh, Tommy, you dropped your truck!" the teacher exclaimed quickly. Tommy looked at her in surprise and earnestly corrected her with the first remark he had made in a long while: "No truck . . . Shoe!" Ingenious tactics may be needed in some cases to help initiate verbal exchanges or other learnings. What works with one baby, however, may not always work with another.

OBSERVATION SKILLS NEEDED

Many of the flexible, subtle, and integrative skills that we have been suggesting as important to build into a training program depend crucially on adults becoming better observers of their own and of infant behaviors.

Providers need to become first-rate noticers. Sure we may notice a runny nose or the first flush of fever. Do we also notice 24-month-old Isaac's sullen pout as his favorite teacher turns to care for another toddler, taking her attention away from Isaac, who cannot yet bear to share "his" caregiver? Do we notice that when we ask two-and-one-half-year-old Jimmy to pick up the crayon that has rolled under the table, he can only comply when a full gesture of pointing accompanies our words? The word "under," which we assumed that he understood by itself, really has no meaning for this child yet. Have we noticed that Janet seems to tune out adult talk addressed to her? In her overly-crowded, overly-noisy apartment, the distinction between talk meant for her and general noise level has not become clear. Such distinctions will need to be made very carefully with her. Training in observation skills is so very important, a never-ending learning process for all of us, and a foundation for the provision of ever-more-responsive care.

TRAINING METHODS OFFERED

When planning caregiver training, consider these points.

- 1) Lectures should be short.
- 2) Workshops should be frequent. These should encourage caregivers to experience sensory stimulations themselves. They should allow caregivers opportunities to arrange furniture, and learning and living spaces for optimizing the care given to infants. Workshops can include role playing between adults as well as practice with babies.
- 3) Audio-visual aids and reading materials should be provided. Trainees should

be encouraged to learn by browsing through audio-visual media. In recent years, many useful films, film strips, and reading materials have been created which can serve as resources.

4) Diary feedback should be used daily during the training sessions. What did the trainees think of today's sessions or activities? What was unclear about a given presentation? What kinds of information or materials does the trainee feel he or she still needed, but did not find on the agenda of the training session?

5) Caregivers should have an opportunity to create toys and games.

Training should include a variety of opportunities for providers themselves to create and make materials suitable for language and sensorimotor games, such as a five-page book for baby to "read." Providers need practice in choosing appropriate pictures to create books for babies. A picture with a single subject in large and colorful format is most suitable. Juice, dog, baby, ball, shoe, banana, hamburger--pictures of these may be very interesting to a toddler.

In making sensory toys, for example, a caregiver might fill orange juice cans with macaroni and other objects, then seal the cans for use as sound shakers. When we participate in creating toys and games for babies we become more involved in our program because it really is ours.

6) Training should provide an opportunity to brainstorm the learning potential inherent in particular toys, experiences, activities, and settings.

What can a baby learn from:

- two wooden basting spoons?
- hearing you label pictures in a book for her while she is snuggled on your lap?
- a crib mobile dangling just over his toes?
- a leisurely bath?
- a wind-up toy?

ROLE OF TRAINING SUPERVISOR IMPORTANT

If you are a trainer of infant care providers, whatever your methods of training, be sure that a sense of wonder and joy at the great strides in learning and growth which characterize the infancy period percolates through all the information and skills you share with your staff. Attitudes and values are as important as the practices and know-how you impart. When but in the first year of life will a human creature triple its weight, happily and easily? Or move from quiet, horizontal, immobility to toddling verticality? Or change from quiet observer to expressive, vocalizing commenter and communicator? Or make the awesome change from a creature with a curled fist to an expert in picking up dust tidbits using just his thumb and forefinger?

Providers and parents, who do their work well and sensitively with infants, can count on helping a human being become the best person he or she can be for almost four score years. In the midst of endless routines, of small cares and crises such as staff shortages, infant illness, occasional cranky times, outbreaks of biting, etc., caregivers need to be sustained by a training supervisor who believes in the work they are doing. A training supervisor can encourage staff by lending a helping hand both literally and figuratively!

IS EFFECTIVENESS ASSESSED?

How can you tell whether your training program for providers of infant care has been effective? Observations can be a very useful aid. You can make your observations more specific and more formalized by using checklists which mention the kinds of caregiver provisions and interactions and arrangements which you have been teaching about in a training session (Honig & Lally, 1975). Are babies being read to more now that you have demonstrated some techniques of reading to babies? Are caregivers talking more to babies as they diaper them?

Casual observations made on a regular basis, if you are sure of what you are looking for, can also be helpful. Are the providers now arranging activities that seem to promote a baby's interested and sustained explorations or problem solving attempts? Is discipline positive, consistent, and clear? Do you hear fewer long-distance "No-Nos" being called across rooms to infants? Do providers make use of task reminder checklists which you have provided for them? Such flyers can often help us to refresh our memory of different activities and program ideas which the training session covered.

SUMMARY

Let us try to summarize all the areas which should be covered in a good training program for infant providers, whether care takes place in a center, a home or in a family day care home. Even a half dozen suggestions may at first seem an indigestibly rich smorgasbord. If training is carried out over a period of time, and providers are given lots of chance for feedback, the result will be an increase in quality care for infants, wherever it is offered. Training should meet the needs of adults for feeling competent as caregivers, yet continuously interested in learning more ways to enrich baby's experiences, to respond ever more effectively to baby's cues, vocalizations, signals, and signs of readiness for new learnings. Training should also integrate all the basic areas that we have touched upon so that, in daily care, the provider deals with a whole child and not with "the crawler," or "the biter," or "the talker" or some other single facet of the development (Lally, Honig & Caldwell, 1973).

Training should provide concepts and knowledge about infant rearing which can be internalized and used to promote positive caregiving practices, not only by providers in day care centers, and in family day care homes, but also by parents in their own homes.

Summarized below are six major training topics basic to providing caregivers the

knowledge and skills that they need to care for infants. Of course, in addition to these six training topics, sessions on parent involvement and on skills in communicating with parents will be essential.

- 1) Child development knowledge should include:
 - a) information about how a young child develops in all areas: language understanding and usage, sensory, perceptual, moral, cognitive, social, and motoric abilities; and
 - b) skills which help a caregiver promote growth in all these areas through integrating knowledge into games and activities.
- 2) Piagetian theory presented should include:
 - a) detailed explanations of the six stages of the sensorimotor period, as well as concepts of the pre-operational period; and
 - b) skills which will help the caregiver determine the stages at which an infant is operating by observing characteristic ways in which the infant responds, solves problems, and interacts with the environment. Other skills needed will be the kinds of games and presentations which will facilitate an infant's learning of concepts, such as the permanence of objects, and the relations of means and ends.
- 3) Information concerning the ecology of child care settings should include:
 - a) the uses and arrangements of space, time, and materials which are appropriate for infants; and
 - b) the ways in which cognitive, language, and sensorimotor experiences can be carried out or offered as integral aspects of daily care routines.
- 4) Emotional growth discussions should offer:
 - a) knowledge about emotional growth and development, including Erikson's stages and some principles of behavior shaping; and

- b) ways in which caregivers, for example, can nourish the development of basic trust. How can a caregiver nurture autonomy and initiative in a toddler, at the same time remaining sensitive to that toddler's dependency needs? Skills in promoting emotional growth should include sessions on the use of positive reinforcers, on the use of distraction techniques, on "what no-no means," on the timing and style of adult inputs and responses, etc.
- 5) Health care, nutrition, and safety teachings should include:
 - a) available needed information; and
 - b) skills to promote positive practices with babies. Sessions should be included on the relation between feeding and the growth of emotional attachments, trust, sociability, and autonomy that can be made an integral component of meal times.
- 6) Training in observation and recording techniques should include an examination of:
 - a) the kinds of observation techniques useful for caregivers. (With sampling, event sampling, and interaction records demonstrated explanations about the use of checklists, rating scales and other records); and
 - b) assistance to caregivers learning to notice where a child is "at" developmentally, so they can "match" offerings, arrangements, suggestions, questions, and teaching styles to a particular baby's level of understanding, personality, and discoveries at a given point in time. Caregivers not only learn observation skills but also how to keep records and how to monitor their own individual program efforts with each infant.

CONCLUSION

Only when we, through ongoing training activities, actively involve ourselves in becoming the kinds of caregivers who indi-

vidualize and optimize personal growth experiences, for and with each infant in our care, can we really begin to give full meaning to those old letters that stand for what every baby needs, TLC--yes, Tender Loving Care in a Total Learning Context.

REFERENCES

- Ainsworth, M. D. S., and Bell, S. M. Mother-infant interaction and the development of competence. Unpublished manuscript, Johns Hopkins University, Baltimore, Maryland, 1972.
- Caldwell, B. M. Film entitled: "How babies learn." Available from the New York University Film Library, N.Y.C., 1967.
- Harlow, H. F., and Zimmerman, R. R. Affectional responses in the infant monkey. Science, 1959, 130, 421-432.
- Honig, A. Curriculum for infants in day care. Child Welfare, 1974, 53, 633-642.
- Honig, A. S., and Lally, J. R. How good is your infant program? Use an observation method to find out. Child Care Quarterly, 1975, 4, 194-207.
- Lally, J. R., Honig, A. S., and Caldwell, B. M. Training paraprofessionals for work with infants and toddlers. Young Children, 1973, 28, 173-182.
- Yarrow, L., Rubenstein, J. L., and Pederson, F. A. Dimensions of early stimulation: Differential effects on infant development. Paper presented in a symposium at the meeting of the Society for Research in Child Development, Minneapolis, April, 1971.

The Care and Finding of Infant Caregivers

by Roger Neugebauer

SELECTION

What does the ideal infant caregiver look like? Now that this country has developed a bit of a track record in serving infants in centers, we are coming to appreciate that this ideal caregiver is truly a special person. Directors of infant centers have found that a caregiver must possess this unique combination of attributes to be effective:

Patience--the ability to cope with babies' frequent crying, messiness, and orniness.

Love of Children--a fondness for all infants that encompasses both deriving pleasure from them and conveying warmth to them.

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Knowledge of Child Development--an understanding of the stages of physical, mental, and social growth of infants and of the curriculum activities appropriate for each of these stages.

Stamina--the agility and energy to actively interact with infants for many consecutive hours without losing either alertness or enthusiasm.

Organizing Skills--the ability to meet the highly individualized feeding, sleeping, diapering, and socializing schedules of a group of infants and to maintain accurate records of their behavior.

Other attributes deemed important include compatibility of caregivers' techniques with the center's curriculum, ability to relate to parents effectively, creativity in providing stimuli, willingness to learn, maturity, and sense of humor.

While there is considerable agreement on necessary attributes, there are conflicting opinions on whether these attributes are best acquired through experience or training. Most directors place heavy emphasis on seeking caregivers who have had experience with infants (especially their own). The findings of Jerome Kagan in his infant day care study seemed to validate this emphasis. Kagan had success in staffing an infant center with women from the community who had had children of their own, who seemed warm and responsive with children, and who had little more than a high school education. (See Kagan interview in CCIE, Spring 1978.)

However, a recently completed national infant study by Abt Associates found that training had stronger effects on caregivers' classroom behavior than did experience. Greater education and more specialized infant training in caregivers were associated with higher frequencies of social interaction as well as with more teaching of language and verbal concepts. Infants under these caregivers care also exhibited less severe distress. On the other hand, neither previous experience nor tenure in current job were found to predict differences in caregiver behavior. (See Abt).

In finding ideal caregivers, the recruitment and selection techniques employed in centers with older children will be generally applicable (see "Staff Selection," CCIE, Summer, 1978). However, given the current lack of caregivers with specific training or experience in infant care, it is vital to observe candidates interacting with infants for extended periods. There is no better way to assess their patience, warmth, creativity, and child-rearing techniques. For the same reason, it is also critical to have a two to four month trial period during which the director and the new caregivers can mutually decide whether they indeed possess the desire and ability to be effective with infants.

STRUCTURE

There are a number of factors to consider in organizing the staff into an effective structure:

---Continuity of care. Anyone who is involved with infant care is aware of the controversy over the importance of a primary caregiver for infants. The findings of Jerome Kagan, as well as the daily experiences of infant centers, provide reassurance that the care of infants can be shared between parents and centers without diluting their attachment to their parents or harming their intellectual growth. There is even a growing awareness that within the structure of the center infants have the adaptability to relate to multiple caregivers. Infants should not, of course, be required to relate to a parade of unfamiliar faces. But if the environment of the center enables infants to develop a sense of stability and security (for example, if the physical setting is comfortable and familiar, and if the staff is consistently responsive to their physical and emotional needs), they should be able to respond meaningfully to three or four familiar caregivers.

---Length of Work Shifts. It is often argued that if caregivers are required to work with infants longer than five hours in a shift, they will cease to be responsive. Once again, experience in the field seems to downplay this concern. Interviews with experienced infant directors and caregivers revealed that in practice individuals are able to work with infants from six to eight hours, given a few breaks, without losing their effectiveness.

Lynn Glenn, the head teacher at the Eureka Infant Center, Eureka, CA, observed that teachers' responsiveness does fade noticeably at the end of the day, but that this fade-out seems to affect all teachers whether they have been on duty six or eight hours. What is happening at this point is due more to the tiring of the infants with their resulting increase in straining crankiness.

Caregivers also noted that their endurance varied with the age of the children. With the very youngest infants, caregivers can work shifts up to eight hours without severe strain. However, around the age of ten to fourteen months, when the demands and activity of the babies escalate, the length of an effective shift decreases noticeably. As the children increase in age, the number of hours gradually increases again.

---Staff:Child Ratio. The consensus among infant care staff surveyed was that the appropriate ratio for quality infant care is in the range of 1:3 to 1:5. The findings of Abt's Infant Study, as well as the observations of caregivers, indicate that when ratios are decreased below these levels (to 1:6 and below) child distress increases and social interaction decreases. Directors noted that when ratios are increased to 1:2 or 1:1 teachers spend more time interacting with each other than with the children.

As with length of work shifts, there appears to be a relationship between ratios and ages. However, with ratios the pattern is the reverse of that for work shifts. The most stringent ratios (1:3) are required for the youngest infants (3-6 months) and for older infants (11 months and older), while the least stringent (1:4) are required for infants ages 7-10 months (see Willis).

---Group Size. The consensus among infant care staff surveyed was that the optimum group size is about ten infants. If groups are larger than this, there are too many adults and children for a mutual familiarity to be established. In addition, the level of noise and activity in a much larger group can be distressing to infants.

---Staffing Patterns. The following are a few arrangements that centers have found to work effectively with infants. There is currently little evidence which would indicate the superiority of any of these patterns over the others:

Primary Caregivers--Two or three primary caregivers for eight to ten infants. One to three aides available to supplement staff during periods of stress and to relieve them at the end of the day. Caregivers assign themselves primary responsibility for three to five infants. (See Willis.)

Zone Plan--Three teachers and a supervisor responsible for up to twenty infants. Adults are assigned responsibility for activity areas (diapering, play, feeding) rather than specific children and rotate among areas. Staff work five-hour shifts so there is a morning and an afternoon staff with additional aides available during the lunch hour. (See Herbert-Jackson.)

Family Grouping--Two adults responsible for two infants, two toddlers, and six preschool children. Older children are encouraged to interact with infants. The Learning Center, Philadelphia, PA, assigns one male and one female adult to each group.

Grandparent Plan--Caregiving staff supplemented by elderly persons who are each assigned specific "grand-children" for three to five hours a day. The Griffen Gardens Infant-Toddler Center, Terre Haute, IN, assigns one pediatric nurse practitioner and three Foster Grandparents to a group of eight infants.

PERFORMANCE

When all is said and done, it is the performance of the caregivers that determines the quality of an infant center's services. Selecting good staff, structuring them effectively, and providing them with good equipment are all necessary ingredients of high performance. What combines all these ingredients into effective performance is leadership.

In infant care, there are a number of performance problems which present leadership challenges. The most common of these is the tendency of staff members to slip into custodial care routines. Caregivers sometimes get so preoccupied with meeting infants' physical needs that they stop providing for sensory stimulation and social interaction. A related problem is the temptation to become lax about record keeping. Because children's needs are so individualized at the infant stage, it is critical to maintain daily records of children's schedules, experiences and problems. Yet this paper work can be tedious and easy to neglect.

Other common performance problems include excessive chatting among staff members when they should be interacting with the infants, responding differently to the "stars" and the "villains" among the infants, and failure to respond appropriately to infants' needs for care and stimulation. To counter these problems and to secure optimum performance, directors have found a number of approaches effective:

---Focusing caregivers' attention on the center's goals. A center's curriculum goals need to be specifically defined and clearly understood. These goals should provide a focus and direction for the style and content of caregivers' interactions with infants. Without goals, caregivers' behavior can become random, inconsistent, and conflicting.

---Making caregivers responsible for designing the center's curriculum and for planning daily activities. Teachers naturally have difficulty getting

enthusiastic about carrying out plans and activities which are dictated to them from above. When they share responsibility for developing the curriculum, their performance is stimulated. They understand the curriculum since they have planned it themselves, and they are personally committed to making it work because it is "their" curriculum. This personal investment in the program should enable teachers to resist falling into custodial routines and becoming lax about record keeping.

---Monitoring program performance on an ongoing basis. Sometimes an infant care staff can become so engrossed in specific activities that they fail to notice when the thrust of their overall activities is drifting away from their goals for children. It is helpful to develop some informal but regular mechanisms for evaluating the performance of caregivers both as individuals and as a team. Someone from outside the team, whether it be the director, and educational coordinator, a teacher from another room, a parent, or an outside consultant, could periodically observe the caregivers and provide them with specific but informal feedback about their performance. Records could be designed to track the incidence of the specific behaviors caregivers are trying to discourage or foster. Or videotapes could be made to enable caregivers to observe and analyze their own behavior.

---Providing support to caregivers in solving problems. Growth and development occur in very subtle and often mysterious ways in the first years, and infants are unable to give any verbal clues about their developmental progress and problems. As a result, caregivers, possibly more so than teachers at any other age level, need someone they can turn to for advice in meeting infants' developmental needs. Frequently, advice is needed in dealing with the physical ailments of infants or in assessing apparent developmental problems. In addition, a resource person should be available to provide suggestions on appropriate curriculum activities and on dealing with the many needs and concerns of parents.

MORALE

Maintaining staff morale can be a serious challenge in an infant center. When staff morale slumps, so does performance. Unfortunately, the infant center setting seems to provide many more forces which reduce morale than enhance it.

The continual stress that infant caregivers are under can be discouraging. Older children can meet most of their own physical needs and are able to engage themselves in activities for long periods of time. Infants, on the other hand, require nearly continual attentiveness by caregivers. At the same time, the individualized, and often unpredictable, schedules of the infants mean that caregivers cannot set the pace of their own day.

Stress is also caused by the frequent crankiness of some infants. No matter how much a teacher loves babies, the continual crying of an infant can be nerve-racking. It is especially frustrating when the infant will not respond to comforting.

Another common source of stress for the infant staff is tension in their relationships with parents. Parents of infants, particularly of first-born infants, are often guilt-ridden about leaving their infants in day care centers and nervous about adjustment and health problems. When a child is having difficulty, the parent can intentionally or unintentionally make the caregiver feel that she let the parent down or that she failed in some way.

Morale can be affected when caregivers fail to get any sense of accomplishment from their work. Babies do not provide direct feedback to caregivers--they don't draw pictures to hang over your desk or blurt out precocious phrases. Their signs of development can be subtle and easily overlooked by caregivers.

Finally, infant caregivers are often regarded by their peers or themselves as not being real "teachers." Teachers of older children are frequently of the opinion that the infant staff members

"have it easy--they're working with the babies."

Fortunately, directors have found a number of approaches that are effective in bolstering morale:

---Providing stimulating and varied experiences for caregivers. Unlike machines, human beings are poorly equipped to perform repetitious tasks and wear out quickly both physically and psychologically under such circumstances. The most direct way to combat stress is to build some variety into caregivers' work.

Variety can be provided simply by seeing to it that staff members are able to take breaks during the day, by giving teachers a half-day off once a week, or by offering as much vacation time as possible. Within the working time itself, variety can be provided by continually introducing new ideas or activities into the curriculum. Assigning caregivers limited organizational tasks outside the classroom (raising funds, keeping the books, designing new play structures, or performing home visits) has proven a refreshing change of pace for teachers in some centers. Other centers find that the variety provided by working with mixed age groups of children is sufficient to counteract stress.

Directors can also look outside their centers for means of providing stimulation. Visits by caregivers to other infant centers have been found to be an effective means of recharging batteries. A more ambitious approach which has also worked well is for two infant centers to exchange a pair of teachers for extended periods.

--Enabling caregivers to get feedback on their performance. Sometimes staff members who are feeling disconsolate about the futility of their efforts can be comforted by a well-timed word of praise. More often, however, the only feedback which can really be convincing is actual evidence they themselves witness of some direct result of their efforts.

What may be needed is to train caregivers to detect the subtle signs of change that infants provide. Some of the monitoring techniques described above could be designed so that individual caregivers receive comments or data on their performances. In parent conferences, directors could encourage parents to discuss in the presence of the caregiver the changes they observed in their child which they attribute to the center. Several directors noted that some individuals seem incapable of deriving satisfaction from working with infants no matter how much training and support they are given. It is best if the caregiver and the center can recognize this early and if the caregiver can be quickly shifted to another age group or maybe another profession.

---*Encouraging caregivers' growth as individuals and professionals.* In the long run a caregiver's morale will be determined by whether he/she is challenged by the job. Once a caregiver starts going through the motions without thinking and begins responding mechanically to children, then the stresses and frustrations will begin to weigh heavily. On the other hand, if an infant caregiver can become intrigued by the mysteries of development in the early years, her excitement and curiosity in working with infants should be a continuing bolster to her morale.

A primary objective of a director should be to stimulate this excitement and curiosity in caregivers. Stimulation can be achieved through an effective in-service training program. (The next issue of CCIE will share directors' ideas on mounting such a program.) Caregivers' eagerness to improve their knowledge and skills can also be stimulated by having a curriculum which clearly relates caregiver activities to infants' needs, by using specific developmental problems of individual infants as springboards for discussing related developmental situations in all infants, and by reinforcing the pleasure that caregivers receive from growth of infants in their care.

Directors should also recognize the many facets of caregivers' personalities. It is not uncommon for directors who are totally committed to the child care profession to expect equal dedication from their staff. While this level of intensity can be maintained for a few years, over a longer period it can cause a caregiver to burn out. Caregivers should be allowed and encouraged to pursue their outside interests.

If infant caregivers can be supported in their total growth as individuals, as well as in their growth as caregivers, their ability to remain as a vital force in an infant center will be strengthened.

HELPFUL RESOURCES

Herbert-Jackson, Emily, et al. The Infant Center: A Complete Guide to Organizing and Managing Infant Day Care. University Park Press, 233 East Redwood St, Baltimore, MD 21202 (\$15.75).

Infant Day Care: A Preliminary Policy Study. Abt Associates, 55 Wheeler St, Cambridge, MA 02138.

Willis, Anne and Henry Ricciuti. A Good Beginning for Babies: Guidelines for Group Care. NAEYC, 1834 Connecticut Ave, NW, Washington, D.C. 20009 (\$4.50).

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Training Techniques for Better Caregiving

by Roger Neugebauer

Training makes a difference in the quality of care infants receive in a child care center. The National Day Care Study by Abt Associates recently substantiated that an infant caregiver's level of training is directly related to the frequency of her social interactions with infants and her teaching of language and verbal concepts. Yet a full blown training program is a luxury few child care programs can afford. Therefore, CCIE interviewed infant care directors from around the country (see credits) to collect training concepts and techniques that

can be implemented on a meager budget and yet make a difference.

GROUND RULES FOR EFFECTIVE TRAINING

1. Training should be an attitude, not a program. For training to be effective, it must be viewed, not as a package of workshops and readings, but as an active process resulting from all staff members being open to learn, to change, and to grow in all their daily activities (Silverman).
2. Training should touch caregivers "where it hurts." Training must not only relate to the needs of caregivers, it must also relate to their "wants." Care-

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givers will not be motivated to take advantage of training unless they perceive it as satisfying a critical need of their own.

3. Training should open avenues for application. A musician can't learn how to play a violin without actually practicing on a violin. Likewise, a caregiver can't integrate a new child development concept into her way of thinking and behaving until she has applied or experienced it with the infants.

4. Training should instill confidence as well as competence. Caregivers need to feel confident in their mastery of child development concepts and skills as well as in knowing that what they are doing really matters. If they react to infants uncertainly, this may affect the infants' feelings of trust and security.

5. Training should focus on child development. Above all else infant caregivers must understand very well how children develop in the early months. Knowledge of curriculum activities is useless if a caregiver doesn't know when or why to apply them.

6. Training should also address interactions with parents and peers. Caregivers must be able to relate effectively with adults as well as with infants.

EFFECTIVE INSERVICE TRAINING TECHNIQUES

Alongside Apprenticeship. A new employee spends her first days closely observing the principle caregiver in her room. The principle caregiver carefully explains what she is doing and why. This not only orients the trainee to the philosophy and procedures of the center, but also forces the caregiver to reassess her teaching behavior. The first few days the trainee is free to observe, but she is gradually given caretaking responsibilities.

Orienting Observations. A new employee can also be oriented to the program by performing either a "naturalistic" or a "directed" observation. For the naturalistic observation, the trainee spends a short period or series of short periods in the infant room noting any significant adult or child behaviors. For directed observations, the trainee enters the room with evaluation forms which direct her to observe and take notes on the atmosphere in the room, the caregivers use of space and equipment, the potential hazards, the children's interactions with each other and adults, etc. The "directed" approach is especially helpful to employees new to infant care who may not even be aware of what to look for in an observation. (The contributor of this idea, Phyllis Silverman, suggested that it might also be useful as a means for evaluating the awareness of job applicants.) Both approaches are concluded with a discussion with the director about their observations and reactions.

Problem Solving Discussions. In a staff meeting the director introduces a recent child-, parent-, or staff-interaction problem for the staff to discuss and solve. During the discussion the director describes how broader principles of child development or interpersonal relations relate to the specific incident. In the next staff meeting, the outcome of their attempted solution is assessed.

Directed Discussions. A discussion on a topic which is of special interest due to recent incidents is scheduled. Staff are asked to think about this issue in advance, to make classroom observations relating to the issue, or to note questions they have on the issue. During the discussion the director does not lecture, but encourages staff participation and directs the conversation along productive channels. At the conclusion related reading material can be distributed.

Child Studies. Caregivers observe and take notes on children in their care using any of three approaches. Caregivers may perform medium-to-long-term *child tracking* on particular children, noting behavior characteristics and

changes. They may engage in age tracking by observing for one or two weeks children at a specific age level to note developmental characteristics of that age. They may undertake behavior tracking by focusing on all incidents of a specific behavior for a week, noting provoking incidents, caregivers' reactions, and outcomes. Caregivers discuss these observations at regular staff meetings. The director reacts to the written observations to help caregivers improve observation skills.

Individualized Projects. Each caregiver selects a project related to her/his particular interests. Teachers may elect to plan an activity or design a piece of equipment to facilitate children's learning a specific skill, to research a specific behavior problem, to redesign a portion of the classroom, or to evaluate the relative effectiveness of various pieces of equipment. At the conclusion the project is shared in a staff meeting.

Brainstorming Sessions. The director proposes a behavior problem for which a solution is needed or a learning objective for which curriculum activities are needed. Staff members propose all ideas that come to mind--only positive suggestions are permitted, not negative or evaluative comments. After 30 to 60 minutes, brainstorming is halted, and suggestions are critiqued one-by-one in terms of developmental appropriateness and resource requirements.

Individual Conferences. The director meets with individual caregivers on a regular basis to discuss their personal growth and career development objectives, their progress in achieving these, relevant resources available, and ways in which the director can be supportive.

Specific Feedback. The director observes individual caregivers interacting with children, parents, or other caregivers and notes particularly appropriate or inappropriate actions or mannerisms. The director feeds these observations back to the caregiver. This feedback is most useful to the caregiver in changing her behavior when it is given while the

incident is still fresh in the caregiver's memory, it focuses on an event (fact) and not on reactions to it or inferences about it (opinion), and it is given with no strings attached--i.e. the director doesn't require the caregiver to do something about it. (See CCIE, Summer, 1978.)

Audio/Video Recording. Caregivers are recorded on audio or video tape in their caregiving routines. The recording is played back for the caregiver either in private for the caregiver to digest or with the director present to assess and discuss. This is particularly effective in making caregivers aware of speech patterns or body language to which they themselves are oblivious. Taping should be done only at the willing consent of the caregiver and should consist of a series of tapings over a year to inform the caregiver about their effectiveness in changing their behavior. Various centers have borrowed taping equipment from local libraries, cable television operators, and Head Start programs.

Training Days. Some centers are able to afford closing the center for one or more days and having an intensive period of training. For such a long period of straight training, it is vital to utilize a variety of active techniques (i.e. role playing, discussions of video tapes, outside speakers, learning-by-doing exercises, films, etc). A full day of passive lectures could be deadening. Some centers use these occasions to reflect upon how things are going and to search out improvements. Others seek to stimulate creativity by introducing new techniques and theories. Still others are less concerned about communicating specific content than they are about raising caregivers' consciousness about the implications of and the center's seriousness about specific issues. In any case, it is helpful to break caregivers out of their routine habits and to put them in a proper attitude for fresh thinking by meeting somewhere away from the center.

First Aid Workshops. In Blooming Grove, New York, the local Volunteer Ambulance

Corps provides workshops for child care workers on artificial respiration and other emergency procedures.

Introducing New Faces. Many centers have outside experts come into their centers to make presentations. These experts may include consultants, college instructors, or experienced staff members from other centers. In addition to specific expertise, outside trainers add fresh insights and a change of pace to a training program. These arrangements are most beneficial when the lecturer can also come into the center, observe the program, and interact informally with the staff.

Cooperative Workshops. Centers in a community cooperate in sponsoring workshops for child care workers. By sharing resources centers are better able to afford bringing in outside experts. Also the interchanges among child care workers from different centers are nearly as valuable as the sessions themselves. In Somerville, Massachusetts, centers expanded a series of cooperative workshops into formal courses for which participants could receive undergraduate or graduate credit for minimal fees.

Making Presentations. Caregivers in the center are given responsibility for preparing and presenting a lecture or workshop on specific caregiving techniques. This presentation could either be for other caregivers in the center or community or for the center's parents. In the process of preparing, the caregivers' own training will be expanded and reinforced; and their confidence in their skills will be strengthened.

"Careteachers Choice." The Center for Infants and Parents in Columbus, Mississippi, has a binder in the staff lounge into which "careteachers" can insert xeroxed copies of articles they found

to be helpful and stimulating. This resource has the advantage of not being readings assigned from above.

Stimulation Games. Caregivers are assigned hypothetical planning tasks (such as to redesign the center's interior or exterior space or to plan a new after school component) and are told to proceed as if there were no physical or financial constraints. The entire staff discusses the completed "ideal" plans noting how successfully they would facilitate the goals of the organization as well as what aspects of these ideal plans the center could implement on its current budget.

Director's Diary. The director keeps a record analyzing the strengths and weaknesses of each training effort. This is referred to as a basis for planning future training.

Using Books and Films. Directors recommended many books and films which they found effective in their training programs. A bibliography of these recommended resources will be included in the next issue.

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IV parent relations

On Looking Back: Parents Evaluate the Effects of Infant-Toddler Day Care

BY ELLEN GALINSKY

"I feel guilty," a mother says, recalling her decision to place her child in an infant/toddler care center. Other parents used similar words: "worried"--"excited and scared"--"uncertain."

The reasons for this turmoil are not difficult to fathom. Infant/toddler care is a relatively new and small scale development in our society. "I had nothing personal, nothing from my own background to base my decision on," one mother says. Most other parents are in the same position--they lack a core of experience of their own to reach back to for comfort, for guidance. They don't know what their child will turn out like and they fear the worst: a child who stops loving his

or her parents, maybe shifts his or her affections from the parents to the caregivers, a child without a solid sense of self, a child so dependent on other children that he or she is afraid to resist the group, a child scattered, diffuse, aggressive.

Yet they hope for the best: they hope that their relationship with their child won't change or will improve and that by being with professionals, their child will get an even more positive start in life and learning.

This professionalism has led most of them to the infant/toddler center. "I didn't want someone who could close the door with my child and do anything she wanted," one mother says. "I wanted a place where they were knowledgeable about young children, about how they grow and how they think." To arrive at this doorstep, many have had to step over a major societal assumption: that a baby belongs at home with a mother--or a mother-like person. "People

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say to me: How can you do that? Put your babies in an institution?" reports the mother of a baby and a 2½ year old. Another parent says that her own mother refers to the center as "That Place."

Although the effects of infant/toddler care have been researched, most of those studies have focused on the children while they were attending programs. Little has been done from the point of view of the parents. And even less has been done from the perspective of several years later. Yet that is what most parents considering infant/toddler care wish for: older, knowledgeable parents to talk to, parents who once had their children in infant/toddler care and who now have had time to see the results, parents with the wisdom of hindsight.

Feeling that such an article would be useful, I got in touch with several infant care programs and through them, with a dozen parents whose children had begun infant programs no younger than four months old and had "graduated" approximately three to five years ago. I interviewed them about how they felt infant/toddler day care had influenced and affected them and their children.

All the parents I interviewed described a similar process they had gone through, a process that could be compared to passing over one or more mental hurdles. Looking at what the parents say more closely, one notices that they use words like "expected" or "unexpected" and "supposed to be" or "not supposed to be," "should" or "shouldn't." All of these parents had pictures in their minds about the way that things were supposed to be. These pictures were not always well defined; they could be cloudy or diffuse, conscious or not. These pictures--I call them images--have been constructed, bit by bit, from childhood on, representing the parent's hopes, dreams, and plans.

When the events of their lives matched their expectations, they were elated. When they didn't, they were caught in a maelstrom of feeling: dissonance, sadness, anger, depression, shock. They, then, either found it possible to restructure their images or to restructure their lives,

leading to feelings of success, or they continued, even these years later, to feel caught in the vise of a contradiction.

This process of adjusting images to realities took place in one or more of the following major areas:

TO BE EMPLOYED OR NOT

Parents have images of whether or not the mother should be employed when her children are young. These images have their roots in parents' earliest years, in their feelings about their own parents' employment. These images are then further shaped by many other events--what one's friends do--how it works out, as well as the prevailing cultural climate. In the past, fathers were to work outside the home and the mothers of young children were to stay home. The numbers of women with infants and toddlers who are employed have increased dramatically, to the point where approximately one-third of these mothers work outside the home. The societal expectations are still in flux, and many women feel a simultaneous pressure on both sides of the issue.

Those mothers who had to work but didn't want to and who still today don't believe in it, live with an uneasy truce. Perhaps they have sat on their feelings, or denied them, but usually their regret flares up fast, as intense today as it was several years ago: "I had to work--but I wish I hadn't."

In the Boston area, Joan Costley, Nancy Leinbach, and Mav Pardee interviewed 50 families on their experiences and feelings about infant/toddler care for a book they are writing. They found that these parents who didn't want to work were likely to make child care arrangements that were unsatisfactory, that they were often the ones that frequently moved their children from one child-care place to another.

This issue can be the source of conflict between parents: a mother who wants a job, a husband who disapproves, who perhaps feels threatened. Or the opposite

can be true: A woman who wants to stay at home and a husband who feels that he has lost the woman he first married and wants her to go back to the way she was, wants her to take a job. These conflicts, if never settled, remain a source of discomfort, anger, and tension today.

Images are not static. Some parents who begin with the image of not being employed change their minds.

PATRICIA DOBYDNIO

Patricia is just such a parent. She is married, now has two children, and works in a hospital full time.

"My son," Patricia says, "was born in April and I was on leave, home with him. On the first of July, my husband lost his job. On the first of August, I cut short my leave and came back to work.

Temporarily, her husband cared for the baby. Patricia found an infant center she particularly liked: "because of their facilities, the educational background of the staff, the variety of the program.

"Even though this program was only a quarter of a mile from where I worked, I felt guilty and angry all the time. I felt that the year that I wanted to spend with my son had been taken away.

"When my husband got a job, I then had a choice. I realized then that I wanted to work, that my son was getting good care, that our relationship was fine, that both my career and my son were important to me, but that I didn't have to choose one over the other, that I could have both. When I realized that I wanted to work, that got rid of the anger--and the guilt went away, too."

For some parents, there is no decision. Employment is an economic necessity that they accept. For others, it is a psychological necessity: "Having a child was a big decision for us," one mother says, "but I knew that I wouldn't be happy being a full-time mother."

When a mother's employment, whether motivated by economic necessity or by a psychological conviction, is generally seen as a good step, when it conforms with parents' images of how they want to raise their child, then this is one factor which leads to a positive evaluation.

In a study of 50 employed and 50 non-employed mothers of older children, Marian Radke Yarrow came to a similar conclusion: that the mother's child-rearing is most affected not by whether she is employed but by whether or not she wants to be employed. Yarrow found that those mothers who want to work outside the home but don't because they think they shouldn't show the greatest problems in childrearing.

WHAT KIND OF CHILD CARE

Parents also have images about the kind of child care they want--and don't want. Some describe dreary pictures of places they would hate to put their child in--places with rows and rows of cribs, with stranded, desolate-looking children.

Joan Costley, Nancy Leinbach, and Mav Pardee discovered that parents' images about child care changed with time. Before the baby was born, parents put more emphasis on how the child care facility looked, on equipment, cleanliness and order. Afterwards, they cared more about the personality of the caregiver. They noted that parents often initially hoped to find a caregiver or teacher who was just like them, a substitute or replica, but later they saw that that was usually impossible and became more accepting of someone who had different attributes, particularly someone who had qualities the parent thought he or she lacked.

When parents have settled for a place that they are less than satisfied with, again a dissatisfaction remains and rides with the parents into the child's later years. Whether defensively or regretfully, they often say that they should have found another place, but they didn't, they couldn't.

Those parents who do make a change feel elated--even after the passage of time.

DAISY ALVERIO

Daisy, a college administrator and the parent of two young children, was able to make such a change. She originally had her child in a program that fit her image, that pleased her, but then the price went up, and she and her husband decided to look elsewhere.

"I looked at a lot of different programs. In some, I just walked to the door and saw a sea of what looked like twenty-three kids going crazy. I didn't even walk in the door. It was like something out of Dickens, like a warehouse for kids.

"A number of the other parents had left the program I was in. Three of them went to the same place so I went there to look. The space was terrific. There were Sesame Street characters on the wall and there was even a backyard playground.

"On the first day I went there, I met the teacher-director. She seemed like a nice, warm person. But I stayed for a couple of hours, and there were no activities going on. The only interaction between the teacher and the children was: 'I'm changing you.'--'I'm feeding you.' The kids were just roaming around.

"My gut reaction was that the people were nice, but there was something wrong.

"I came back another day and again, everyone was just sitting around. No one read to a child. No one ever talked to a child. But I thought, maybe I was being too critical, so I left Alexis there for a short time. When I came back the teacher said they had all gone to the park and that he had been fine.

"The next day I went to work. When I got back I found him sitting in his umbrella stroller. He had been there for hours. The director said, 'Well, he didn't want to get out of his carriage.'

"I couldn't believe that she said that. The way she told me was like it was completely acceptable--not that it was even the lesser of two evils.

"The next day I told them, 'Even if Alexis cries, I don't want him to spend the day in his stroller.'

"But the next day when I came back, the identical same thing happened. The teacher said, 'We tried to get him out, but he cried.'

"The following day when I came in, he wasn't in his stroller. I guess the teacher finally realized that I was upset. But he was sitting by himself, crying, and no real effort was being made to involve him.

"That night, I decided that I would try to improve the situation. So I wrote a five-page letter of some activities they could do.

"The following day, I told the teacher that I would come at a certain time, but I came back earlier. Alexis was back in that damn carriage!

"That's when I decided to withdraw him. Not only were there no activities, but to save money, this place was using hourly workers and people were coming and going all the time. The teacher didn't have any training either. So it was like the blind leading the blind.

"When you have your child in a place that you don't like, you either go crazy or have to deny it. I was going crazy. All day at work, I was thinking about Alexis.

"I took him to another place. He had a difficult adjustment, but they had a completely different attitude. The teacher said, 'Yes, he's upset, but we expect this at first and we need to give him time.' She said, 'First we're going to do this and then that to help him adjust.' She was reassuring and confident.

"It was like night and day. It was the same child--the same separation problems, but at the second center, I was dealing with someone who knew what she was doing.

"It makes me feel great to have made that change. You know how when you've done something that's right, you have that great, great feeling. I have that--even now."

Bernice Berk, a New York City psychologist, over the past several years has happened to work with about a dozen or so children who have had what she deems as poor infant/toddler care experiences. They were not abused or mistreated, but neither were they really noticed. As in the center that Daisy Alverio describes, the caregivers didn't really communicate or connect with the children. They were one of many in a large group. Bernice Berk observed these children, now kindergarten age, to be withdrawn. They wandered, they rarely connected to anyone, and if upset, were not easily comforted. While not all children in such settings will end up with these problems and likewise it is impossible to know where these patterns of rootlessness come from, Bernice Berk is convinced that these particular children "weren't helped by poor child care arrangements."

HOW DO THE CAREGIVERS FEEL ABOUT MY CHILD?

This is the major but often unspoken concern that parents have once they have enrolled their child in a child care program. "At first, parents ask a lot of detailed questions," Polly Macpherson, the social worker at the Summit Child Care Center in Summit, New Jersey, says. "They ask for tiny pieces of information. They try to get a real picture of what's happening when they leave: 'How do you know when a baby's wet?' 'Do you hold them when you feed them?' Behind all these questions is the thought 'Does the teacher like my child? Does the teacher think my child is very special and treat my child with love?'"

If the answer to those questions was no, parents, when asked to think back about child care, remain negative.

NANCY PORTNOF

Nancy was a college student when she put her youngest son in day care. Five years later, it is very fresh in her mind.

"I made a bad choice, a choice so bad that I think that today there is a disruption in my son that had its genesis in that experience.

"Gabriel had a warm teacher, but she was the kind who liked to teach, and who liked quiet, orderly children. He was a very physical child who didn't fit her values.

"I didn't realize it. I was overjoyed by the space, but I missed out on the fact that the teacher didn't like what Gabriel could do best. He was almost in a punished situation. No other children were physical--except one, who was seen as a bully.

"I had thought that I was capable of seeing, but here I didn't. My older daughter had gone to the same place and prospered, but he was a different child.

"It was my fault. The director would have been receptive, but I didn't approach her. I didn't know until it was too late.

"I finally woke up when he started biting. But before that I had missed a monumental thing about my child. Three quarters of the year had gone. And it wasn't as if I never spent any time there. I had and I had even wondered why no one congratulated him on what he could do in the gym area.

"He brought his biting right with him into [nursery school]. Finally, I said to myself, 'Look, you've made a lot of mistakes--but now that you realize it, it's time to stop.'"

From then on, Nancy has attempted to make sure that her son's teachers appreciate his physicality. "This experience may have hurt him," she says. "No, it didn't ruin his life--but it might have!"

On the other hand, when the teachers appreciate and value a child, good feelings radiate out to the parent and the child and are remembered years later.

HOW DO THE CAREGIVERS FEEL ABOUT ME AS A PARENT?

New parents think a great deal about how well they are doing as parents. In deciding about many of the child rearing issues--whether to pick up a crying baby or how much and when to feed the child--parents are thinking about how they are measuring up: are they a good parent or not. Their sense of identity as a parent, is, at first, unsure.

Polly Macpherson, the social worker from Summit Child Care Center, feels this parental uncertainty poses a danger for an infant/toddler center. "Parents can have a tendency to abdicate responsibility to the infant care staff," she states. "Parents will say, 'You tell me when he's ready to walk'--'You tell me when she's ready to be potty trained.' 'He has a runny nose, do you think he should go outside?'

"Those are legitimate questions," Polly says, "but we [at the center] have to mitigate against that tendency to take over, so we turn the question around: 'What do you think?' we ask parents."

Phyllis Silverman, the program director of the Infant Care and Resource Center of Cornell University has the same point of view. She says, "Day care centers can do parents a great disservice by simply answering questions. We have to be supportive, but at the same time, make sure that parents know how to look for answers themselves."

When they first use childcare, it can be difficult for parents to say goodbye, to feel safe in entrusting their child to others. What is less known is that caregivers can have the same kinds of difficulties. After working hard with a young child all day, it can be hard for the caregiver to say goodbye in the evening. Inadvertent actions can cause problems: the caregiver who forgets to send home a

sweater; the parent who brings a lollipop at the end of the day after the caregiver has been emphasizing nutritious food. Depending on the people and the program, these normal feelings of competition can solidify into a hard core of jealousy, or can be dispelled and supplanted by a cooperative atmosphere. The attitude of staff towards the parent is an important factor that parents consider when they think back on infant day care. It makes the difference between memories tinged with nostalgia or rivalry.

THE OUTCOME FOR PARENTS

Even those parents who are primarily positive, do not recall their child care experiences as totally good. They remember both good and bad days. Their children undoubtedly got sick. There may have been one staff member they didn't like. Their child may have come home with a bite or scratch from another child, or a scab from falling on the playground. Another parent may have said something offensive to them.

But when parents had passed over these four preceding mental hurdles, and their images tended to match their experiences, they then could think of these bad times as incidental, as problems that were solved, rather than major roadblocks or disasters.

Such parents felt that infant/toddler care had not weakened their bonds with their children, but in many cases fortified them.

--"Infant day care strengthened our relationship. The hours that I spent with my daughter were limited, but during those hours, I have her one hundred percent attention." The mother of a 5½ year old

--"We couldn't have raised our child as well by ourselves as we did with a child care center. When you spend all your time with a child, you end up pushing that child away. Because we have less time, we value it more, and we have more patience." The father of a 3½ year old

The research on children attending high caliber infant/toddler day care programs echoes these parents' observations. In the most well-known study of 70 children, Jerome Kagan of Harvard University concluded that 20-month-old children in day care were no less attached to their mothers than home-reared children were.

Parents also saw productive features in their opportunities to have a relationship with the staff and other parents, mentioning that they had learned about discipline techniques and how to talk or listen to their child better.

--"Before I put my son in a center, I felt isolated. The burden of raising him was greater because I felt that my influence was the only one he'd get. [After enrolling him at a center]. I was gratified to share that responsibility with people I trusted. It took the onus off me. He had others that cared about him. I became able to see him more objectively. I never felt alone in raising him."

The mother of a 6½ year old

Parents felt that their children had many opportunities for learning.

--"The center could provide many activities: finger painting, cooking, movies, trips to farms and zoos."

The mother of a 3½ year old

--"He had a lot of physical and mental stimulation. He's now very well developed."

The father of a 3½ year old

The research conclusion to date about the effects of infant day care on intellectual development, according to Henry Ricciuti of Cornell University who recently summarized this research for the U.S. Department of Health, Education, and Welfare, is that socio-economic class seems to be the most important variable. Good day care does seem to enhance the cognitive development of children who are deemed "at risk" or from "deprived homes," but not for children from normally stimulating homes. Just how long these early gains last is debatable.

J. Ronald Lally of Syracuse University found that 100 low-income children who attended a quality infant care program at 3 years old scored on an average 14 points ahead of a control group of 100 home-reared children. At 5, the differences between the two groups was still substantial, but in grade school, the difference washed out. But was this because of poor schooling? Will these early gains some day make a difference? These are still important questions to be researched.

The parents I interviewed appreciated access to early diagnoses of disabilities, as well as health and nutritional care.

The parents' perceptions of improved health care has been corroborated by a study headed by Mark Golden of 400 children in average infant/toddler programs in New York City.

Parents felt that their children made gains in self-confidence, that they had very good feelings about themselves.

By far the biggest asset, one that parents reported again and again, was in the child's sociability.

--"My child is a future social worker. She's outgoing. But it's a chicken and egg situation: Would she be that way anyway or is she that way because of group day care?"
The mother of a 5 year old

--"Group life isn't an issue for my son. It's a way of life. That's not to say that he goes into a group so comfortably, but once he gets comfortable, he is really comfortable."
The mother of a 5 year old

--"Our child is an only child. Had he stayed just with us, he would have been a quasi-adult. Because he was in day care, we think he is more sociable. Day care gave him brothers and sisters, siblings of many different backgrounds and races. He is gregarious."
The father of a 5½ year old

--"Our child is eager to play with older and younger children. He

knows how to share. He has been taught that fighting isn't the way to solve things."

The father of a 3 year old

Jerome Kagan found that the 35 children he studied were less apprehensive in new situations but not more gregarious. Greta Fein and Elaine Rubin Moorin from the Merrill-Palmer Institute compared toddlers who had attended a quality day care center for 3 months or less, with those who had attended 12 months or more. They found that the long-term children initiated twice as much make-believe, evidenced more social behavior, and maintained such behavior longer than the short-term children.

Parents do not see these relationships with other children and adults as replacements--but extensions of the child's family.

--"Children like to be loved by many different people. But we have stayed first in our son's affections."

The mother of a 3 year old

The crucial issue, these parents and researchers are saying, is whether the infant/toddler care program is good. By good, parents detailed many of the qualities that professionals list when they describe "quality of care"--small groups, low teacher/child ratio, well thought out program with activities appropriate to the child's developmental level, well-arranged materials and equipment in an attractive space, individualized attention given to children, well-trained or educated staff, a supportive, positive, friendly atmosphere. But parents are going beyond these criteria to say that what is good for one child in a group might not be good for another; likewise a program that worked for one sibling might not for another.

"Good" for the parents means that they were fairly positive about their own employment, that the center fulfilled most of their images of child care, that the child was seen as special and that the parent was treated with respect.

When these factors go askew, the parent sees ill effects being wrought, temporarily at least, in the child's feelings about him or herself and in the child's ability to socialize. Conversely, when these criteria are met, the parents see growth gains in these two areas: self concepts and social ability. For these parents, the guilt feelings they once harbored have gone, and in their place are pleasure and pride.

Dealing with Parent Concerns

Ideas from Janice Miller,
William Alexander,
Phyllis Silverman,
Sheila Abramowitz, and
Bonnie Neugebauer

Staff members in an infant toddler center must prepare to help parents, as well as the children, adjust to the program. In a CCIE survey of centers that serve infants, toddlers, and preschool children, all the directors agreed that the parents of infants and young toddlers are much more anxious and concerned about the program than are parents of older children. Directors identified four factors that cause these parents to be especially anxious. To begin with, they may feel real or imagined disapproval from their friends and family. While having 3, 4, and 5 year olds regularly cared for out of the home has by now become a generally accepted practice in our society, there are still widespread misgivings about child care outside the home for the youngest children.

In addition, for many of these parents, this may be their first experience with raising children or with leaving their children in the care of others. This inexperience may cause them to feel insecure and to be uncertain about a child care arrangement. Added to this inexperience is the fact that the children are not able to communicate information to parents about what they are experiencing in the program. Having little or no feedback from their children, parents may feel helpless or at the mercy of the child care staff. Finally, parents' concerns may be heightened by their strong feelings about the vulnerability and dependence of very young children. They may fear that since infants and, to a lesser extent, toddlers are unable to effectively advocate for themselves, that their needs and interests are more likely to be ignored.

All these pressures, anxieties, and insecurities of parents are encountered by the child care staff. The way the staff responds to these concerns will significantly influence whether they become constructive or destructive forces in the relationships among staff, parents, and children. Specific suggestions on shaping appropriate responses to the most common types of parent concerns are outlined below. Underlying these specific suggestions are four general guidelines. To be effective in responding to the needs and interests of parents, the center should provide:

1. Quality care for their children;
2. Information about their children, their children's experiences at the center, and child developmental theories and applications;
3. Opportunities to influence the program and the treatment their children receive; and
4. Support in coping with their feelings and child rearing problems.

ANXIETY ABOUT SEPARATION

A parent often suffers as much, if not more than a child, from separation anxiety. (S)he suffers when (s)he is leaving the center and sees the child crying in protest to his/her departure. (S)he suffers after (s)he has left the child at the center and is plagued with guilt feelings for being a negligent parent.

Not all parents react to separations in the same way. As Phyllis Silverman describes, "A really heartbroken cry can send the strongest and most decisive parents away feeling guilty and ambivalent about their life style. On the other hand, some parents feel reassured when their baby cries when they leave, secure that they are still the important person in their baby's life." For some parents, observes William Alexander, the anxiety and guilt may surface in hostility toward staff members. Other parents, embarrassed over their guilt, may avoid revealing their feelings to staff members.

Phyllis Silverman recommends starting early to help parents prepare. "We are honest at the enrollment interview about what parents can expect: that at different stages in a child's development, children will protest parents' leaving, more than at other stages, and that parents may have difficulty with this." Bonnie Neugebauer makes home visits to families before school starts. The primary purpose of these visits is to help the toddler become familiar with her for the first days of school, but they also serve to make the parents more trusting and comfortable with her as a caregiver.

Staff, as well, need to be prepared. Training should be provided to them on how to look for cues to anxiety in parents and how to appropriately respond. The point needs to be made also, not to interpret all parent hostility and complaints as an overreaction to their anxiety. It is easy to overlook legitimate complaints in the first weeks, and this can undermine trust.

Most infant/toddler programs find it helpful to encourage parents to spend more time in the center for the first week. According to Silverman this enables the child to ease his way into the program, the staff to learn the parent's way of relating to the child, and the parent to become familiar with the program and the staff. She also suggests making parents feel welcome by providing adult furnishings and space for adults in the classrooms.

If it doesn't "gel" for a parent during a week or more of extended stays, Janice Miller invites the parent to confer with her "on a more personal basis about their doubts and anxieties." Alexander expects staff members to be willing "to spend extra time with parents building trust level" during these critical early weeks.

Staff need to give parents opportunities to discuss their feelings. They should acknowledge that parents are having separation difficulties without dwelling on them. Parents should be encouraged to discuss their feelings openly. Staff should listen and be accepting, not judgmental. They should also talk to the

parents daily about how their child behaved after they left and throughout the day. Parents should be assured that if their child is experiencing prolonged unhappiness, they will be called.

It is also helpful to allow parents to decide how to deal with the situation. The staff will want to be clear in setting basic guidelines (such as expecting the length of parents' visits to gradually decrease) and to be supportive in offering suggestions (such as to call the child in mid-morning or to leave some prized article of the parent such as a hat or bracelet). But parents are most likely to benefit from the experience if they decide what will work best for them and their children.

INSECURITY ABOUT PARENTING

Inevitably there will be parents in an infant/toddler program who will be insecure about their ability to raise children. These parents will often lean on the staff for guidance on difficult issues such as feeding, toilet training, and discipline. They will be all too eager to relinquish responsibility for making tough child raising decisions to the center's staff.

It is, of course, totally inappropriate for centers to assume major responsibility for the care of the children. Staff members need to make a deliberate effort to avoid taking over major decision-making about the child. Instead they should support parents in developing a sense of competence and control.

In part this can be facilitated by offering facts and not opinions when parents ask for advice. The staff should provide parents with information on child development and child rearing, but must let parents decide how to apply it. Caregivers should not offer unsolicited advice. It is not uncommon for teachers who are experienced and well-trained to develop negative attitudes about the skills and practices of parents. If these attitudes are conveyed to parents, whether directly or indirectly, they can reinforce parents' insecurity as well as damage

teacher-staff relations.

Staff can help parents develop their parenting skills by helping parents become observant about their children's growth. At the end of the day, teachers can describe to the parents some of their children's accomplishments during the day. It can be shown how these events demonstrate the developing skills of the child.

Staff members can utilize many approaches for getting information and resources into the hands of the parents. Miller provides parents ample opportunities to observe other parents, as well as teachers, thus conveying child rearing techniques through modeling. Sheila Abramowitz organizes parent workshops "that are ongoing throughout the year on subjects such as toilet-training, sibling rivalry, separation, and child development." Alexander invites small groups of parents to attend "parent education breakfasts" to discuss specific topics or to share feelings, concerns, and needs. Neugebauer fosters opportunities for parents to share their concerns and suggestions with each other.

CONCERN ABOUT CARETAKING

Parents, especially those who are new to day care, may have serious concerns about the quality of caretaking the center provides for their child. Their questions may include "Do they love my child? Does (s)he receive significant individualized attention? How do they meet routine needs such as feeding, toileting, and sleeping? How is my child protected from contagious illnesses and from children's aggression?"

The most fundamental way in which a program can respond to concerns about caretaking is to provide high quality child care. If this does not happen, parents' concerns will only increase over time. But even in the highest quality programs, approaches need to be developed for making parents aware of the quality of the program, for satisfying their specific concerns, and for gaining their confidence in the program.

Parent concerns must be addressed by providing them plentiful information and feedback. Information sharing can begin even at the time of enrollment. A parent can be forewarned about the types of experiences their child is likely to have as a normal part of life in a day care center. Miller alerts parents in enrollment interviews, that their children, being exposed to a group of children for the first time, may be more susceptible to common illnesses. She suggests that parents be reassured that children do develop immunities in time, so that after their first six to twelve months at the center illnesses will gradually become less of a problem. Silverman recommends to parents who work that they plan in advance for back-up care when their child is too ill to attend the program. Unfortunately such back-up care is often unavailable.

Another issue to alert parents about in advance is aggression. Particularly with toddlers, parents need to be told that there will likely be times when their child will develop aggressive habits or when (s)he will be the victim of aggression. Silverman explains to parents that aggression is "viewed as part of normal development and is treated that way at the center." She explains that every effort will be made to protect children from being bitten or hit, and that when incidents of aggression occur the aggressor will not be punished or shamed.

Once the child is in the program, most directors encourage parents to visit the center or to participate in the classroom, so they can see firsthand what happens in the program. Since many parents who work are unable to do this, Neugebauer suggests varying the activities that occur at the beginning and end of the day so that when parents pick up and drop off their children they can get some feeling for what happens in the program.

In addition it is essential to keep parents informed by talking to them when they pick up their children and telling them what their children did during the day. Parents should be informed not only about developments in areas where they have expressed specific concern, but also about

any significant accomplishments, problems, or noteworthy incidents. This will ease parents' uneasiness over not knowing what goes on during the day, as well as help assure him/her that the teachers are attentive to his/her child.

Since it is not always possible to talk at length to all parents every day, many centers try to maintain communication in some written form. At Basic Trust Infant-Toddler Center, for example, there are big white boards outside of classrooms with a surface that can be written on and erased easily. Beside each child's name, the teachers write (daily) "what the child ate, when (s)he slept, what activities the child participated in, and any special information that seems pertinent. . . . The chart also has a section for parents to write special information instructions."

Parents will also have a deep interest in how well their child is doing--whether (s)he is adjusting well to the program, whether s(he) is developing normally. These concerns can best be addressed by supplying information in the ways described above. In addition most programs also hold periodic parent conferences (varying from monthly to yearly in frequency). In a conference, staff members respond to concerns about the center and the child raised by the parents, as well as provide a report on their observations of the child in the center.

When a parent is troubled about a problem they perceive their child is having, the staff must provide the parent support. If the parent is overreacting to or misinterpreting certain patterns of behavior, the staff should help the parent see that their child is developing within normal ranges. Parents sometimes become concerned, for example, when their child is not comparing well with other children of the same age in the center. Rather than simply advising the parent not to worry, the staff should provide this parent information about relative rates of development which may lead her/him to the conclusion her/his child is developing normally.

When the staff too is concerned that the problem may be real, they should not offer an opinion about it unless it is clearly within their range of expertise. If they cannot make a definitive judgment about the problem, they should help the parent find a qualified person to make an assessment. When a specific problem is diagnosed, the director should offer whatever help the center can provide, describe alternative courses of action, and allow the parent to decide which way to proceed.

Parents' confidence in a program is also increased when they believe they can influence how their children are cared for in the program. In order for parents to believe that they have real influence, the staff must not only demonstrate openness to listening to their complaints and suggestions, but it must also seriously consider these points, and act upon them where appropriate. If parents voice concerns about certain center practices (such as infrequent diaper changing or inappropriate discipline techniques), but see no changes in these practices, their confidence in the program may plummet. This does not mean, of course, that every complaint or suggestion needs to result in an immediate change in the program. When the director decides that a change is unnecessary, the parent who suggested it may still feel his/her input matters if the director can demonstrate that the suggestion was seriously considered, and explain why it cannot be accepted.

Responding to the Special Needs of Parents of Infants and Toddlers – Techniques of Summit Child Care Center

BY ROBERT LURIE

Parents of infants and toddlers in group day care have "special needs." Ask these parents what their concerns are and they will often reply, "I want to know what's happening to my child during the day," or "are they caring for my child the way I would?" These statements are expressions of the parents' needs to know about the details of their children's lives and to maintain control over these details. While these feelings are symptomatic of most parents choosing group day care, they are particularly acute among parents of infants and toddlers.

Compared even to older pre-schoolers, infants and toddlers are dependent on adults. In group day care the emotional, custodial, safety and developmental needs must be met for a large part of the day by adult, non-parent caregivers. As a result, parents of these children come to share this dependence in meeting their

own needs to know and control. Their concerns, values and goals must be translated to the children by the caregivers. Since infants and toddlers go through some particularly value-fraught, parenting/child-rearing experiences (toilet training, bottle weaning, etc.), the interaction between parents and program can determine whether the program is successful in meeting the parents' needs.

What follows is a brief description of the parent involvement system in use at the Summit Child Care Center in Summit, New Jersey. The Summit infant-toddler program provides full day care for 60 children of working parents at two centers. The parent input mechanisms described below are based on a practical understanding that parent input and involvement will help the program to function more smoothly and a philosophical belief that, to the extent possible in group day care, parents

should remain in control of their children.

PROGRAM ORGANIZATION

Summit's infant toddler program is organized around tracking groups. The tracking group, consisting of one teacher and four or five children (aged 6 months to 3 years) is the functional unit for the day's activities. The caregiver develops a close relationship to the children in their group and intimate knowledge of their progress. This tracking group system has clear advantages for the daily curriculum and for the children but, in addition, it provides direct and obvious connection for the parent to a primary caregiver of their child--someone who can give "hands on" information about the child and who can offer an immediate response to a parent request.

TRACKING BOOKS

Each caregiver maintains a tracking notebook on the children in their group. There are two standard forms kept in the book and filled out on a daily basis. One form is maintained by parents and filled in when the child is dropped off for the day (see Form A). It contains information about the child's evening and morning--mood, eating, sleeping, etc. There is also space for special requests or other information the parent wishest to impart. There is a corresponding form filled out by the caregiver at the end of a child's day (see Form B). It describes what the day was like, critical patterns during the day (sleeping, eating, toileting) and general information about the child. While this formal mechanism doesn't substitute for direct communication between caregiver and parent, it does guarantee that a great deal of basic information is passed on, and it does respond to the parent's desire to know what happened to their child each day. Also since the Center is open longer than a caregiver's eight-hour day, sometimes parents miss seeing the tracking teacher when they pick up their child--a look in the tracking book provides a concise description of the day from someone who was there.

PARENT REP SYSTEM

In each infant program there are several parent representatives who volunteer to play an important role in program-parent communication. On a monthly basis they call every parent in the program and ask if they have any concerns or questions or needs. They also communicate any messages about Center activities or policy changes. The parent reps meet each month with the program coordinators and the director to raise the parents' concerns and questions. The issues are discussed and answers provided. Notes of the meetings are distributed to all parents to indicate what resolution came from their questions. The parent rep system has been an effective tool for addressing concerns and significant policy changes and new ideas have developed from the meetings, including the tracking system described above.

INTAKE

Parent involvement begins before a child actually enrolls in a program. When a space is available an intake is scheduled which includes the completion of social history focusing on the child's development, and health evaluation with the Center's nurse. In addition a visiting period is scheduled during which the parents stay with their child in the program to help them become comfortable and also observe the program in action so they too have a "hands on" understanding. At this time they are introduced to their parent rep and given a general orientation to the agency. From the beginning parents are encouraged to ask questions and find out everything they need to know to be comfortable in placing their child in the program.

CONFERENCE

At least every six months there are formal parent conferences with the tracking caregiver. At this time a progress report is given to the parent based on an informal developmental assessment and parents have an opportunity to ask questions and raise concerns. Naturally a conference may be requested

Form A

SUMMIT CHILD CARE CENTER INFANT-TODDLER CARE

DAILY INFORMATION FROM PARENTS

EATING			SLEEPING				MOOD		BM	OTHER INFORMATION THAT WILL HELP US IN CARING FOR YOUR CHILD
Time	What	Amount	To Bed	Up	Uninterrupted	Restless	Good	Irritable		
M										

Form B

SUMMIT CHILD CARE CENTER INFANT-TODDLER CARE

Child				Caregiver				Week of		COMMENTS				
EATING		SLEEPING		ELIMINATION		MOOD		ACTIVITY						
Usual Pattern	Light	Usual Pattern	Light	Usual	Potty	Loose	Content	Happy	Involved	Irritable	See Board	Outdoors	Participated	Write on Back
														Check X

at any time in response to an immediate concern.

PROGRAM DINNERS

In the spring and fall each program has family dinners at 5:30 p.m. The children help cook the main course and families bring desserts. After dinner the children see a movie while the caregivers show the parents the current activities in the program. The dinners are an opportunity for informal communication between parents and staff, a lot of fun and extremely well attended.

SUPPORT GROUPS

Parents of infants and toddlers typically experience a variety of emotions when they choose to place their children in day care

and return to work--running the gamut from guilt to relief. The Center's Coordinator of Parent Services periodically facilitates the organization of parent support discussion groups. In these groups, which meet as long as the need is felt, parents can discuss mutual concerns and common feelings. Often simply realizing they are not alone and hearing other workable solutions helps parents deal with their own particular situation.

This total system of parent-program communication has evolved over the years in response to either expressed or perceived parent needs. Each element does not work perfectly all the time but taken together it does provide a variety of ways for parents to find out about what is happening for their child in the program and how they can mold the program to meet their individual needs.

Vnitty gritty

Routine Caregiving

BY ANNE WILLIS AND HENRY RICCIUTI

Much of a caregiver's time in a program for infants is spent in routine or obligatory care routines, namely feeding, diapering, and managing naptime. By understanding that these activities are potentially valuable learning experiences for the baby, the caregiver can use them to accomplish many goals for these infants. Attention is directed in

the three sections of this chapter to aspects of care important in the first year of life.

FEEDING

Feeding is a good example of what might be regarded as a routine or obligatory care activity, but one which serves several important purposes. Besides satisfying the baby's nutritional needs, feeding time offers an opportunity for a young baby to have the caregiver all to himself or herself, to be talked to, to be close. For an older baby, it becomes also a time to find out about new tastes, textures, and colors, to begin to learn names of common objects, to master the difficult job of holding a spoon, maneuvering it into the dish, and balancing it all the way from the dish to that elusive target, the mouth. Learning to hold one's own bottle and eventually to manage a spoon and a cup represent early and important achievements in the baby's increasing efforts to master

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his or her world. The handling of these early attempts at mastery and control by those people caring for the baby lays a base for general attitudes about trying new things, persistence, success and failure.

It is obvious to anyone who has had experience with babies that the nature of the feeding experience changes greatly over the first year of life. The close, peaceful time when a caregiver holds a drowsy baby and gives him or her a bottle soon gives way to a much less serene, more exciting scene when the baby is sitting in an infant seat being given solids. Eventually the baby takes over much of the responsibility for self-feeding, sometimes acting with more enthusiasm than skill.

During the second six months of life, the feeding situation becomes much more a social situation with peers, a time to talk with, smile at other babies, and perhaps share food. The feeding situation should be viewed by the caregiver as providing a variety of opportunities for meaningful experiences.

LINKS WITH PARENTS

With babies of any age, feeding is an area of care where the knowledge of what has been happening at home is particularly important. If the caregiver finds out each morning when and how much the baby ate, she will have an idea of approximately when the baby should be hungry again, so that she can interpret the baby's cues more accurately. It is helpful to keep an up-to-date list of foods each baby can eat and any special information about his or her diet, such as special likes and dislikes or food allergies, near the food preparation area. A daily record of when, what, and how much a baby eats should be kept so that the parents can be informed at the end of the day. New foods usually should be introduced at home, at the discretion of the mother, rather than in the nursery. This is one of the particular areas of care where it is the parents' right to make decisions about changes. The amount and kind of table foods a baby eats should be determined by the parents, who may wish to collaborate with the staff before making

any decisions.

Parents may have special food requests because of cultural or religious backgrounds. These practices should be respected and made clear to caregivers so they do not violate them. The parents may be asked to provide special foods they want their baby to have. If a parent asks that the baby be given new foods by the caregiver, they should be introduced one at a time. Thus, if an allergic reaction should occur, it will be easier to isolate the cause. Caregivers need to find out from parents when the baby has been given a new food at home, so that they can begin to include it or can watch for an allergic reaction to it.

Caregivers should be informed by the parents of any changes in feeding that might be necessary because of minor illnesses.

The information from parents, combined with cues the baby gives and knowledge of the baby's typical schedule, will determine when the caregiver feeds a baby. This approach could be termed a modified demand schedule. As in other areas of care, anticipating hunger and feeding the baby before he or she gets upset will make feeding time much more pleasant and relaxed. In younger babies, cues for hunger may include crying or fussiness (especially when the baby has recently had a nap and has been changed), sucking fingers or hands, or just making sucking movements with the mouth. Older babies are less subtle about being hungry--they cry, too, but if possible, they may move over to where another baby is being fed to watch, cry, or try to induce the other baby to share. Of course, the infant may alter his or her feeding schedule for any of a variety of reasons other than how much and how long ago he or she ate. For example, a baby who is ill or teething may suffer a complete or partial loss of appetite. A baby going through a growth spurt may need more frequent feeding or larger amounts than normally required.

It would be easy in a group program, particularly, to misuse food by falling into the habit of using it as a major pacifier to calm a baby and relieve ten-

sion. Occasional use of a cracker or bottle to console or comfort a baby is normal and very effective, for eating is a pleasurable experience for most people of any age. However, characteristically using food to quiet an infant in situations where the baby is not hungry can establish an undesirable pattern.

FEEDING TIME: CAREGIVER AND BABY TOGETHER

Especially in a group program, feeding time without preparation can be chaotic, disordered, and no fun for anyone. Planning and awareness of the importance of the setting can be the best preventative measures. If possible, feeding should occur in a relatively quiet place, especially for those babies who are distracted easily by what is going on in the room. The caregiver can be more attentive to the baby or babies she is feeding if she does not have to be constantly surveying the room. As is true in other areas of giving care, the caregiver's enjoyment of the feeding situation can contribute to its being a pleasurable experience for the baby. If the caregiver approaches it with a positive attitude, it is more likely to be fun for the baby, too.

With younger babies, and when a new baby comes to the program, no matter what the child's age, several purposes are served by having the same caregiver feed a baby regularly. In general, this arrangement facilitates their getting to know one another. The caregiver can more quickly learn how fast the baby eats, how much, and the baby's style. For the baby, more time spent in interacting pleasantly with a caregiver will allow the baby to get to know the caregiver as someone to enjoy being with and who can be trusted.

Babies should be held when they are getting a bottle, if possible, even if they are able to hold their own bottles. This is a special time to be close to an adult. Propping bottles in a crib or on a pillow for younger babies is a dangerous and undesirable practice. When younger babies are lying down while eating or drinking, there is the possibility of choking. The

practice of putting food (mixed with milk) in a bottle is not recommended. The baby will not get as much food that way because he or she will get tired of sucking. A program in which babies are not usually held when they have their bottles is probably in need either of more caregivers or a discussion of the importance of close one-to-one contact between babies and adults.

In a group program it is likely that the babies' schedules will be different enough that everyone will not be hungry at the same time. However, it is possible for a caregiver to feed two babies at once and have it be a pleasant experience for all three of them. The kind of feeding required obviously determines how many babies a caregiver can feed at one time. She can feed solids to two babies who are seated in feeding tables or high chairs, and when the babies have started feeding themselves, she can manage more than two.

If a baby rejects a food one day, the caregiver will make a mental note of it and perhaps reintroduce the food in a week or two when the baby is hungry. The caregiver should let the baby determine the pace of the feeding situation and adjust herself to how fast or slowly the baby wants to eat. Especially with young babies, pacing the feeding is a part of individualizing care. Some babies drink very fast and efficiently, while others are slower and may lose interest or become tired before they have had enough to drink. Caregivers should be tuned in to this. Adjusting the size of the hole in the nipple may help to make feeding more relaxed. A baby should not be rushed in his or her eating. Some babies are "no-nonsense" eaters--that is, they eat at a fast pace, are very businesslike, and seem to encourage the caregiver to be the same. Other babies, who may enjoy the food just as much, are more receptive to talking and socializing during feeding. Caregivers should respect these differences and adjust their behavior to them.

Some very young babies like to assist the caregiver with feeding by putting a hand into the mouth when it is full of solids

and grabbing or batting the spoon. A small toy or another spoon will sometimes keep the hands busy. Feeding babies solids is no job for a fastidious caregiver, especially when babies are learning to feed themselves. It is very likely that by the end of the feeding session, the baby, the chair, and probably the caregiver will need to be wiped clean. The caregiver must be careful not to have too high expectations for the baby's competencies. Any feeding situation should be free of unreasonable demands for neatness, attention to the job, and persistence, but caregivers should be especially careful to establish a relaxed atmosphere for babies beginning to learn to feed themselves.

As in other areas, caregivers take cues from the baby's interest in grabbing the spoon or helping to begin letting the baby learn to feed himself or herself. The baby can be given a spoon to hold while being fed. Eventually the baby will accomplish the difficult task of getting it to his or her mouth with food on it. An easier beginning for self-feeding is with finger foods such as teething biscuits, pieces of cooked carrots or cooked green beans, pieces of mild yellow cheese, or dry cereal. While these do require small motor coordination, they are easier to manage than a spoon. The baby learns to enjoy self-feeding and gains some control over his or her world. These early attempts should be rewarded with enthusiasm and delight by the caregiver. She should encourage the baby's efforts and give help, for instance, in getting the food on the spoon. She should not insist that the baby complete the job alone. Especially when a baby is just beginning to master self-feeding, it is probably wise that the caregiver not rely completely on the baby's efforts to feed himself or herself, for the process may be so difficult that the baby gets tired and quits before eating enough. A better plan is to provide some finger foods at each meal to supplement what is spoon-fed by the caregiver.

The baby's wishes should be respected, in that he or she should not be forced to eat. The caregiver responds to the baby's interest or lack of it. If the

baby's loss of appetite persists over several days, parents may wish to check with their physician. The opposite is not true; babies should not be fed every time they ask for food. An older baby may still be smacking his or her lips and protesting as the caregiver removes the dish that ten minutes before was heaped with food. Babies are subject to suggestion as are older people, and in a group program there will be many times when the sight of another baby eating will cause a baby to ask for food. Caregivers should use discretion with food and should use it when the baby is hungry, not solely to appease, occupy the baby for a few minutes, or to make him or her happy.

When babies have had enough milk, they will generally either refuse to have the bottle in their mouth and start to fuss, or they will start to play with it. They may also allow the excess milk to dribble out the sides of their mouth. Once hunger has been satisfied, they may fall asleep. Some babies will suck for a few minutes only, then fall asleep, and awaken in a short time to repeat the cycle. This can be avoided by knowing the baby's schedule and feeding the baby before he or she is sleepy. Talking to babies and playing with their hands and feet or touching the forehead with a damp cloth occasionally will help the babies stay awake. This, of course, does not mean that a baby is ever forced to eat or that feeding time is a frenetic, stimulating time. On the contrary, it should be a relaxed, quiet time. Older babies are not so subtle about telling the adult when they have finished, but will cry, try to get down, turn away, spit the food out, play with it, leave the scene, throw the food on the floor, or refuse to open the mouth. Unmistakable, cues! With any group of babies there are likely to be some nutritional problems with allergies or overweight babies, for instance. Caregivers can be very helpful to parents by tactfully suggesting changes in the diet, or that a problem is serious enough to consult the pediatrician.

Quiet play is best after eating, so the baby might sometimes be left in the feeding table with some toys. Older babies,

especially those prone to spitting up, should not be put on their stomachs immediately after eating.

Feeding time can be one of the most enjoyable parts of the day for babies and caregivers if it is prepared for ahead of time and carried out in a relaxed way. Some authorities in early child care say that in the first five to six months of life, the feeding experience is perhaps the most important single situation for close contact and interaction between the baby and an adult. This close interaction, when it is pleasant, helps the baby to learn to trust those people who are caring for him or her. This close situation is one where the baby learns early some of the pleasant contingencies, some of the ways he or she can cause something to happen, such as a smile from another person in response to a smile, or words if the baby first coos or babbles. Feeding time should be thought of as a learning time, a fun time, even if just to find out if a thumb can be fitted into a mouth already full of green beans!

DIAPERING

Diapering is an important routine caregiving activity which, properly handled, contributes to the health and comfort of babies. It can be carried out as part of the total good experience for the baby, or it can be done as quickly as possible without any special thought. As is true with other routine activities, diapering can be a time for the baby to be talked to and smiled at by the caregiver, as well as to get a dry diaper. As the babies get older, finishing quickly does become important, for the babies do not want to take time out from other activities for a diaper change, and they try to leave before the operation is finished. Sometimes a toy to hold makes the short time more tolerable. The caregiver should be aware of how she is handling the baby at this time, whether her style is abrupt and rough or pleasant and gentle.

As has been mentioned many times, much pleasurable, constructive play takes place in the context of routines. For example, an episode where a caregiver is changing

the diaper of a responsive six-month-old baby could easily involve the following experiences for the baby:

Motor activity--kicking vigorously when the caregiver removes confining clothes.

Cognitive activity--the caregiver's face disappears behind the diaper and reappears.

Language activity--caregiver and baby talk, coo, and laugh together.

Social activity--caregiver talks to the baby, laughs with him or her, touches the baby gently, responds to smiles and babbles.

Sensory experience--the feel of being free of clothes, the soft, fresh, dry feeling when a new diaper replaces the cold wet one.

Most importantly, the gentle touch of the caregiver and having a need met without undue delay increases the baby's trust in people. The program is not something that happens only between diapering and feeding, but, rather, during them as well.

Diapering should be done in a single place in the room--on a diapering table with a rim or in a crib with a high mattress that can be wiped regularly and kept very clean. Otherwise germs and infections can be transmitted easily. A crib is a good place for changing older babies, who are typically very squirmy. No baby should be left unattended for even a second, no matter how young or how certain the caregiver is that the baby cannot roll off the changing table. For this reason, it is best to begin diapering a baby only when there is another caregiver in the room, so that diapering can be completed quickly and without interruption. There should be a supply of diapers, pins, lotion, and wet washcloths easily within reach of the caregiver and out of reach of the baby. The routine at Cornell was that the babies were changed as soon after arrival as necessary. The diaper they arrived in was placed in a plastic bag within a paper bag with the baby's name on it and put in his or her cubby to be taken home.

While at the nursery, the babies wore cloth diapers (handled by a laundry service), and shortly before going home they were changed into disposable diapers. Some centers prefer to use only disposable diapers, although one needs to be aware that some babies have allergic reactions to them.

Babies should be checked for wet diapers at least every hour, including before taking a nap and as soon as they wake up from a nap. Babies with a diaper rash should be checked even more frequently. They should be cleaned after each change, and any diaper rash should be treated with an appropriate lotion, salve, powder, or cornstarch. Caregivers must wash their hands before and after each diapering. They should remind each other of this, as it is easy to overlook when several babies need diapering at once. As the babies get older, two diapers are used, the inner one being folded to make a four-ply panel down the center.

Some babies mind much less than others wearing a wet or soiled diaper, but that is no reason to allow them to have one any longer than necessary. Caregivers should remember to note changes in bowel movements that might have implications for what the baby eats or how he or she feels. Caregivers should be alert to symptoms of diarrhea, take precautions to prevent its spreading to the other children, and be sure to keep parents informed of symptoms of possible illness.

NAPTIME

In a day care program for babies, sleeping should be handled in somewhat the same way that eating is--that is, by a modified demand approach. Also, like feeding, napping can be handled best when the caregiver knows the baby's schedule and is tuned in to his or her cues. Handling sleeping is different from feeding in some ways, however; a baby who is crying because he or she is hungry rarely becomes more upset when a favorite food is offered, but a fussy, sleepy baby often becomes fussier when put in the crib for a nap. Some babies sleep regularly and go to sleep easily, while others resist sleep from a

very early age. Sometimes knowing that the baby needs a nap has to determine what the caregiver does, more than whether the baby acts as though he or she wants a nap when put down in the crib. Most young babies will take a morning and an afternoon nap. However, this varies from day to day and with individual babies, and many babies drop the morning nap before the end of the first year. An older baby (over six months) typically should not be put down until he or she shows signs of being tired or sleepy.

The normal variability in babies' schedules and needs for sleep and rest makes it inadvisable to have a rigidly set nap period for all babies in a program. There are large differences, even among babies of the same age, in how much sleep they need and when they choose to take naps. These differences should be respected. Individualizing care means that caregivers respond to each baby's needs as he or she shows them. It is no doubt possible to eventually get babies to sleep or at least stay in their cribs fairly quietly for a set time each day. However, caring for a child according to a preconceived schedule instead of the cues he or she gives undermines the child's growing sense of self as a person who can indicate needs and have them responded to, who can have an effect on the world. Consideration must be given to what message a child gets when put in his or her crib at a certain time each day no matter how he or she feels. Some people have suggested that one of the reasons many children fight going to bed may be that they have been made to stay in bed at times when they were not tired or sleepy.

If an infant program is housed entirely in one room--that is, if babies nap in the room where they spend their waking time--caregivers may find it useful for both themselves and the babies to try to get them on somewhat the same napping schedule, so that activity in the room will not be distracting to babies resting or sleeping. Also, it is likely that babies in a program will naturally tend to fall into similar sleep patterns. Further, having babies on somewhat similar schedules increases the opportunity for taking the group outside or on excursions, since even one baby sleeping means that a care-

giver must be nearby. It is possible, however, for babies to nap outdoors in carriages, playpens, or portable cribs. Some kind of reasonable compromise between completely individualized schedules and a predetermined set naptime for everyone can be worked out in each program. Time away from the babies is very important for caregivers, but breaks should be programmed in at times other than just when babies are napping. Also, some caregivers have noted that the times when only part of the group is awake afford opportunities for play and interaction and for quiet times that are unique.

Naptime is an area of care where consistency in practices from home to nursery and from day to day in the nursery is crucial. The caregiver needs to know each day when and how long the baby slept at home in order to decide wisely when he or she needs a nap. The way a baby is put to sleep at home and in the nursery should be somewhat similar. A goal in a group program should be to help babies go to sleep with little help from the caregiver, as a caregiver for three or four babies cannot always help each one go to sleep individually. A long prenap ritual--for instance, holding a baby and walking around with him or her for thirty minutes--is just not always possible for every baby in a group program. Also, babies differ widely in how they prefer to be handled at naptime. Some babies, especially very active ones, need a "wind-down" period of quiet play before they can relax and go to sleep. This may mean being placed in a playpen to play quietly, being rocked on a caregiver's lap, or perhaps getting a bottle of juice or reading a book together. The baby may still be awake when put in his or her crib, but the quiet time has been a transition between active play and going to sleep.

Knowing when to begin getting a baby ready to sleep involves a certain amount of second-guessing to choose the optimal period before the baby becomes very fussy but not before he or she is finished playing. Cues that a baby is sleepy may include rubbing eyes, showing disinterest in play, clinging to an adult, sucking a

thumb, putting his or her head down, getting clumsy, slowing the pace of activity, becoming frustrated very easily, as well as becoming fussy for no apparent reason.

Just as with eating, the home situation may affect the sleeping routine in the nursery. A parent's absence or guests in the home, for instance, may alter the baby's sleeping schedule. Tension or excitement at home or in the nursery or getting anew tooth may have the effect of making it more difficult for the baby to relax and go to sleep. On the other hand, vigorous physical activity, an oncoming illness, or a period of rapid growth may result in increased napping. A baby who is upset for any reason should not be put down in his or her crib for a nap until having been consoled and comforted. Putting babies in their cribs while they are upset will only make them more upset. Also, most babies cannot go to sleep easily if they are hungry or have a soiled diaper.

Caregivers have to learn not to view naptime as a battle pitting caregiver against baby to see who will emerge the victor. The caregiver should not feel that she has lost if she tries to get a baby to sleep and fails. Caregivers should respond gently and calmly to each baby's needs at naptime, taking time to adjust the naptime routine to each baby.

It is common for some babies to react to being put down for a nap by crying vigorously. Babies differ a great deal in their ability to quiet themselves after this kind of upset. Consistent, predictable handling and allowing the baby to work things out with appropriate support will help the baby develop the ability to put himself or herself to sleep. No set rule can be stated for how long a baby should be allowed to cry in his or her crib before being taken up again. Knowing the baby makes the difference. A caregiver who knows the baby can tell when he or she is past the point of self-quieting. Very often it is more difficult to let the baby cry than to go in and pick him or her up, especially when there are other babies sleeping in the room. A consistent pattern of waiting to put babies down

until they are really tired and letting them work things out for themselves sometimes can help them to learn to accept naptime instead of fighting. Younger babies may need more help than older ones in getting to sleep.

Each baby should have his or her own crib to sleep in each day. The cribs of babies with similar sleeping schedules should be arranged together, and if a large number of babies are napping simultaneously, a caregiver should be assigned to the sleeping room to meet their needs. Otherwise a caregiver should come in periodically to check on the sleeping babies.

Sometimes a baby who will not sleep will rest quietly for a while with a few toys for quiet entertainment in his or her crib. Some babies like to have something to hold onto--a blanket, for instance--when they are going to sleep. Others like the soft sound of a music box or want their pacifiers to put themselves to sleep. Very young babies will nap from thirty minutes to one and a half hours in the morning, and may nap again soon after eating. As they get older (around six months), the morning nap becomes shorter and may eventually drop out all together. Most babies continue their afternoon nap long after the morning one has dropped out.

Babies should be removed from their cribs as soon as possible after waking up from a nap. Leaving them there will only make naptime unpleasant and lead them to resist it. If they must stay in the same room with babies still napping, they can be encouraged to play quietly. Naptime should be followed closely by a diaper change. Some babies wake up slowly and need a gradual reintroduction to the brightness and activity of the playroom. If they are brought in immediately after a nap and put down, they will become very upset. A better plan is for the caregiver in a gentle way to pick the baby up, talk softly to him or her, walk around in the sleeping room for a short time, and then go back to the playroom.

Basing naptime routines on the needs and styles of each baby, expecting variations

between babies and from day to day, will mean that napping will become a natural, even pleasant activity and not an arena of confrontation.

The Health Component of the Child Care Program

BY SUSAN S. ARONSON, M.D.

There are many areas in health which are addressed by day care programs in daily routines. Many are associated with cultural or personal preferences; some are based on scientific information about child health risks and ways to avoid them. The most common sources of health problems for children in day care fall into three major areas: infectious disease problems, injuries, and health problems which are not evident unless specifically looked for (e.g., anemia, vision, hearing). These three major health and safety risks for children in day care are discussed by Aronson and Pizzo in a concept paper on health and safety issues in day care written in 1976 for HEW as a portion of a study of the appropriateness of the Federal Interagency Day Care Requirements. (See Bibliography.)

The health component of the child care program is constrained by realistic limits imposed by budget and competing priorities for staff time. Before attempting to change an existing child care program,

the staff of the program need to critically evaluate the program's accomplishments and weaknesses in the various areas of the health component. For each area of the health component, the following questions should be asked:

- What are the needs of the children, staff and parents in this area? What is the program presently doing to meet the needs? Who is involved in this aspect of the health component now? Who should be involved?
- How is this aspect of the health component being addressed? How should it be addressed? Where is this aspect of the health component taking place? Where would it best take place in the best interests of the children and in the realistic best interests of the provider service?
- When is this aspect of the health component accomplished within the program year? within the child's developmental

continuum? When should it be done?

To achieve decisions which get implemented, remember to include those affected by the activity, those with authority over the activity and those with expertise to bring to bear on the activity in this type of planning. In all areas of the health component, a health consultant can help the program to clearly understand what activities need to be performed, so that priorities can be set and a meaningful commitment can be made by all those involved. It is useful to organize evaluation and planning for the health component around the areas discussed below:

Health Services

The intensity of the health service activities of the child care program depends to a certain degree upon the extent to which children and their families have easy access to health care providers. All children benefit from advocacy efforts to assure each has received appropriate preventive health services and that health concerns of program staff are brought to the attention of the health provider. Both private and public health care providers usually do not make vigorous follow up or preventive outreach efforts and may need to be educated about the potential support that the child care program can give the family in complying with the health provider's recommendations. Health care for infants is particularly important because untreated minor health problems can result in significant developmental impairments in this age group.

Health Records

By helping parents to identify available health services, by working with parents to maintain complete and up-to-date health records, the child care program can play an important liaison role. There is a generally accepted set of health maintenance routines which every child needs. These include immunization and screening tests which help identify health problems amenable to correction. A child care health program need not duplicate the detail or sophistication

of a health provider record, but the child care program health record should document which services have been provided to each child, who provides health services to the child, and any services needed by the child to complete health maintenance routines or to follow up on special problems.

Health Policies and Procedures

Written policies and procedures help staff, parents, and consultants to have a common understanding of the health component. Having clearly documented procedures and policies minimizes the indecisiveness about which routine is to be followed in a given situation. Such policies should specify appropriate individuals to be contacted, the limits of responsibility of the parent, the program's staff and of a health consultant.

Recommended topics for inclusion in health policies for infant care include:

- Admission procedures, including inspection exam and parent-worker communications
- Management of acute illness, including exclusion policies
- Management of injuries
- Safety precautions related to developmental abilities
- Health supervision schedules
- Mechanism of follow-up of health problems
- Medication administration
- Nutrition, food and formula handling, including care for breast fed babies
- Provision for bathing
- Beds, care of linen
- Dental hygiene
- Health education
- Parent involvement
- Emergency plans
- Staff health
- Transportation

Attention to Children with Special Needs

Children with special needs rarely require a very different program and environment from that needed by other children. The primary health care (basic health needs) of special children are not

different from that of "normal" children, nor are their basic development needs different. Routine "basic" care can be supplemented in a "normal" setting for many children so that they may attend programs in a mainstreamed fashion from the start. A good health component should be able to meet the primary health care needs of children with special needs and those without. When special needs children are in care, staff do require training around the area of the special need, preferably provided by appropriate experts in the child's area of special need. Such experts might come from developmental clinics of children's hospitals or medical schools or from other community agencies. Since funding for specialized care is usually fragmented, child care programs must learn how to utilize existing community resources to the fullest extent possible. This means not only connecting with the child's primary source of health care and routine health services, but also identifying those programs where special expertise required by the child is available.

Health Education

Health education includes the general education of all those who may be affected by injuries, illnesses, or common health problems (children, staff, parents, volunteers). It is beneficial for everyone to be aware of her or his role in fostering health and be prepared to respond as an advocate for positive health behavior in day to day situations. Health education should include emergency preparedness, knowledge of first aid management and appropriate methods of management of minor illnesses, awareness of the various aspects of safety and quality of the environment over which we have some control, and the rationale for any of the efforts made in the health component.

Staff Health

The program should assure that sound health practices are included in the hiring and supervision of all individuals in the program. The program should require pre-employment and ongoing annual screening of staff and volunteers for infectious disease problems, presence of chronic dis-

eases which require frequent absence or special regimens or medication, and any other health problems. Unusually frequent, or long absences for illnesses should be investigated.

Dental Care and Daily Dental Hygiene

As with many areas of the health component, dental health education is best accomplished by incorporation of dental hygiene into daily routines. The simple practice of daily toothbrushing in the day care program, rinsing with water after sweets, and frequent use of detergent foods in menu planning promote dental health. Children can start to practice dental hygiene as soon as they have teeth. The experience of having teeth brushed is as important as experiencing face and handwashing to the learning of a young child. In areas where water is not fluoridated and for infants on breast milk or ready to feed formula, fluoride supplements are needed from birth to gain the benefits of a 50% reduction of tooth decay. Parents are often unaware of this need.

Evacuation, Emergency and Disaster Plans

Emergency plans and evacuation procedures need to be visibly posted and frequently practiced. Each individual needs to be knowledgeable about her or his role in emergencies.

First Aid and Management of Minor Illnesses

Program staff need to be able to competently deal with first level management of injury and illness situations. Common problems, such as cuts, bruises, head trauma, colds, diarrhea, fever and earache should be covered in training provided to staff. Regular updating reviews of such training and review of handling of situations as they occur with all staff will help to maintain proficiency.

Safety and Environmental Quality

Safety and environmental quality measures have suffered from benign neglect by many child care programs. It is true that environment cannot and should not be ex-

pected to be absolutely safe or always ideally comfortable. This fact does not justify ignoring the simple ways to reduce health and injury risks. A good preventive measure includes rotating responsibility for a routine monthly safety survey for hazards and environmental problems among staff. Examples of commonly needed corrective actions are removing toxic products from child access areas, installing inexpensive dehumidifiers in areas of dampness, installing portable screens where complete screening is not possible, and identifying maintenance problems with playground equipment.

Nutrition

Nearly all child care programs incorporate some aspect of nutrition into their programs by providing snacks and/or meals. By understanding and utilizing the basic elements of nutrition, including socio-cultural implications, nutrient quality, frequency of food and fluid intake and economic aspects, the child care program can have a persuasive impact on this aspect of health. Simple concepts like promoting breast feeding, avoiding cow's milk before 12 months of age, not including specially prepared iron and vitamin fortified infant formula and using the four basic food groups to promote a balanced diet can be incorporated to help children and their families develop good life long habits. The child care program must model and not just talk about good nutrition. More detailed recommendations for infant feeding are contained in a separate reading prepared on this topic.

Mental Health

The mental health professional can be of great value to the child care program to help staff learn routine methods to assess all the children and to identify and plan for those with special needs. Such consultants can also recommend routine procedures which will better meet individual needs of normal children. A special effort should be made to address the mental health needs of caregivers of young children. Reasonably timed breaks and time for planning is required to assure that reasonable quality of care can be maintained.

Transportation

Some means of transportation should be immediately available to the child care program at all times. When an emergency situation arises there often isn't time to call a cab or rely on public transportation. Calling a parent or some other individual outside the program to provide a car may result in a loss of vital time. Since police and fire rescue vehicles are commonly used to provide such immediate transportation, plans should include alerting these community agencies about the location and nature of the program. In addition, arrangements must be made to release a staff member to accompany an injured child without jeopardy to the supervision of the other children in the program. All vehicles used in the transportation of children and adults should comply with safety standards and should be equipped with suitable restraint devices. The program should require that age appropriate seat restraints be used by all children under 40 lbs. whenever they are transported and that lap and/or shoulder harnesses be used by all others. Even in programs which do not provide vehicular transportation for trips or daily use, pedestrian safety plans for walking to and from the program site, nearby public transport stops and parent education in transportation safety are appropriate.

Administrative Practices

Administrative procedures are needed to foster continuous improvement of the health component year by year. To this end, programs need health records which document which services are needed and which services have been provided, health policies and procedures which help all staff, parents, and consultants to have a common understanding of the health component, staff health measures which assure hiring and appropriate supervision of individuals to carry out the plans of the program, posted emergency plans, appropriate injury reporting for legal and preventive reasons. Inspections and licensing procedures should be considered opportunities for obtaining additional expertise rather than threats to the program's continued operation. Often

licensing representatives who have visited many child care facilities can suggest reasonable solutions to problems thought insurmountable by the program. By focusing special attention on a particular aspect of the program, a licensing representative can help in the evaluation process which makes continuous improvement possible. This is particularly true of sanitarians, fire, safety and building code representatives. When different inspectors present conflicting advice, bringing them together for a face to face meeting at the day care program may help to resolve the conflict.

Using the problem-solving approach for the health component helps to focus attention on significant problems, establish a plan for dealing with the problems and establish a time schedule and priority listing for problem solving. In practice, health component improvement planning has helped to focus discussion of program staff and health consultants on important program problems. Ongoing re-appraisal and planning on an annual basis is valuable. In the interim, it is important for a single individual to be identified in the child care program to be responsible for overall implementation of the health component. This designated individual's relationship to the other staff, to policymakers and to consultants should be made clear to everyone so that problems will be directed to her or his attention and s/he will be provided with opportunities to assure that the program's plans are carried out. This individual's role is to assure that the plans made by decisionmakers or planning body are carried out at the particular site of service on a day by day basis. In many programs, this person is called a health advocate. In a large program, the health advocate may be an individual whose sole role is overseeing the health component. In smaller programs, s/he is likely to be someone who has other duties but who is recognized by the program as the most logical individual to assure appropriate integration of health activities with other activities of the child care program. Unless one individual is stipulated as responsible for the health component, it is unlikely that even the best laid plans will be

carried out. The health advocate should be someone who is available to the program on a day by day basis so that s/he can be the gadfly for fostering health in the child care program. At the same time that s/he is maintaining the health component for the program, the advocate must be able to yield to the other priorities of families and of child care program. Because s/he is involved with the daily activities of the program, s/he will be able to propose compromises and alternative solutions which might not be thought of by any outside person. The health advocate can be a caregiver, social worker, or administrator with special interest in the health area. Since in most programs health will not be the advocate's sole focus, the health advocate must be assisted by supervisory staff and coworkers to identify the best time and circumstances in which to perform this role. Only if everyone agrees to the purpose and intent of the role can it be meaningfully implemented. The goal should always be improvement of care for children.

Summary

The health component is an integral part of the functions of day care. For infant and toddler care, health concerns are particularly crucial to the child's ability to benefit from developmental opportunities offered in the program. The health component of day care should focus on minimizing infectious disease risks, working on injury control and assuring that currently recommended preventive health measures are used by each child.

Infant Feeding Policies

By Susan S. Aronson, M.D.

The world of an infant is a dependent one. Feeding experiences are a unique opportunity to influence how the infant perceives the world. Infants need to be fed in a relaxed, pleasant atmosphere. They need to be cared for by skilled people trained to recognize and respect their special needs, individuals who enjoy what they are doing. Infants need to be picked up, held, and talked to while they are being fed. This kind of gentle sensory contact gives babies a feeling that the world is a safe, reliable place; it helps to create a positive environment for the eating experience.

Breast Milk or Formula Feeding

Infants under five to six months of age need only breast milk or formula. For infants of this age group, feeding is usually appropriate during the day at intervals of no longer than four hours. For nutritional and developmental reasons, breast feeding is preferable to formula feeding, but the parent's feeding choice should be supported. Unless otherwise arranged, an iron fortified infant formula should be the standard formula provided by

the day care program. Ready to feed formula should be conveniently stored in each child care area. Child care workers need to be responsible for all formula feeding and for keeping track of formula supplies so that shelf storage of formula is not excessive. For breast fed babies, a suitable refrigerated (e.g., transported iced in a thermos) supply of breast milk can be brought in daily by the parent. It should be refrigerated until used. Formula and breast milk can be fed without warming.

Introduction of Solid Foods

After five to six months of age, foods are generally introduced to broaden the child's experience with tastes and to work toward a diet which is nutritionally well balanced. Infant formula and breast milk contain the kind and amount of nutrients the infant needs for healthful growth and body development through the first five or six months of age. There is no need nor benefit to early introduction of solid feedings. Babies do not sleep better when fed solids. They sleep better when maturity lengthens their sleeping patterns.

When solids are introduced, special attention needs to be paid to iron rich foods, such as infant cereals. However, as part of fostering normal development, the infant should be encouraged when ready to learn to finger feed, drink from a cup, and use a spoon. As self feeding is learned, the child also develops motor skills. Most infants are ready for foods of coarse consistency between seven and nine months of age. Often, they will not develop an interest in chewing until well after their first teeth have erupted. As long as particulate food is cut small enough to be swallowed whole with minimal gagging and choking, the child need not chew. When an infant shows interest in picking up small objects and putting them in his mouth, bits of food can be offered, beginning with pieces of food such as bananas or peeled apples, moving on to cooked vegetables and meats.

Procedure for Feeding Infants

The feeding patterns of infants vary so that it is imperative to have one child care worker know the schedule and normal intake for each child. Any change in schedule or intake should be discussed with the parents before making the change. If formula is not ordered and maintained by the day care program or a special formula is needed, this should be provided by the parents. Opened or mixed-at-home formula should not be accepted (for sanitation reasons) at a day care center.

A. Preparing to Feed

1. Good hand washing technique is essential when preparing to handle infants. After washing hands, get the formula and other items necessary for feeding.
2. Take the infant to the diaper changing area and change him. Again, wash hands and return to the area for feeding.
3. Prepare feeding. If solid foods are to be offered, present them before the major portion of formula or breast milk is offered.

4. After the infant starts to eat solid foods on a regular basis, offer tap water in a very clean, well rinsed formula bottle at least twice daily. Boiling water, bottle, or nipple is not necessary if the source of water is an approved city water supply.
5. Discard opened or leftover formula as soon as the feeding is completed. No formula should be used if it has been open for more than one hour. Do not reuse partially used nipples or bottles before thoroughly washing and rinsing. Never leave a bottle with the infant in a propped position. Bottle propping or feeding in the supine or prone position should not be permitted at any time. Babies fed lying down choke more easily, are more likely to develop ear infections and bottle mouth (dental caries) syndrome.

B. Formula Feeding Technique

1. Before feeding the infant place a bib or similar article under the chin.
2. Hold infants under six months of age comfortably in a semi-sitting position with head and shoulders supported and cuddled closely. Eye contact during feeding is an essential part of building a trust relationship. Older infants may be fed in a high chair or similar apparatus as long as an adult supervises the feeding to assure that the child drinks in an upright position.
3. Hold the bottle at an angle that keeps its neck and nipple always filled with milk. Generally the hole in the nipple should be just large enough to allow a drop to form slowly on the nipple when the bottle is inverted. An infant who feeds vigorously may need to have smaller holes, while an infant with poorer sucking

reflex may need larger holes to avoid exertion. Test the holes in the bottle before feeding. If the milk flows too quickly, tighten the collar of the nipple assembly tighter against the bottle to prevent air entry and slow down the rate at which milk can leave the bottle.

4. If the infant doesn't respond to the gentle pressure of the nipple near the lips, touch the baby's cheek nearest your body to encourage the infant to open his or her mouth. Sucking can be stimulated by keeping slight traction on the nipple so that the baby must pull to keep the bottle in his or her mouth.
5. An infant may swallow air with feeding. This may be brought up by interrupting the feeding at least once or twice, oftener if necessary. At this time hold the infant upright, gently massaging or patting the back until the baby burps. This may be done at the end of the feeding or any time that the baby stops nursing.
6. Keeping the infant upright at least fifteen minutes after feeding helps to avoid regurgitation of food or formula.
7. Placing a small infant on his or her right side after feeding helps to prevent aspirating any formula that comes up and encourages stomach emptying. A small blanket can be rolled and placed at the back to prevent the baby from turning over.
8. The bottle and nipple should be rinsed immediately after feeding. Any milk left in the bottle should be discarded.

C. Solid Feedings

1. Offer new foods before the formula, while the infant is still hungry. At first the infant will push the food from his mouth with a reflex

action of the tongue. This does not mean that the baby dislikes the food, but that s/he has not learned how to eat from the spoon. It takes time and patience. A small, shallow feeding spoon can be used to put the food into the back of the mouth.

2. Cereal - Introduce new foods in small amounts. One to two tablespoons of dry infant cereal is usually diluted with two to four tablespoons of formula or breast milk.
3. Juices - It is preferable to start with a clear juice such as an apple juice. At first offer diluted juice half and half with water. If the infant refuses water, this is a good way of giving it.
4. Any special juice or cereal must be brought to the center as purchased, unopened and labeled with the infant's name.
5. When other solid foods are introduced, such as fruits, vegetables and meats, these foods can be cooked without seasoning, prepared in a blender and frozen in ice cube trays as individual servings. It should not be necessary for any parent to bring in strained foods since by the time the infant starts on solids, particulate foods or blenderized foods can easily be used.

Introduce new foods no more than one each two or three days so that adverse reactions can be properly attributed to the offending foods. Introduction of solids is an experience in nutrition, not a dietary necessity. Remember that breast milk or iron and vitamin fortified formula can provide an adequate diet for the first six months of life. For a number of nutritional and immunologic reasons, breast milk is preferable to formula feeding. Whenever possible, breast feeding mothers should be supported and encouraged to continue nursing.

Vitamins and minerals are already provided in widely available commercially prepared iron fortified infant formulas. Vitamins and iron supplements are not necessary for infants fed these formulas. For infants not receiving such a commercially prepared formula, supplements of iron and vitamins should be provided by the time the infant is four months of age and continued until the infant has begun to eat a full table food diet. In addition, infants on breast milk and prepared formulas need fluoride supplements to provide fluoride to their developing teeth. Fluoride supplementation reduces dental caries by half. The dose is age specific, and it must be prescribed by a physician. Since these supplements are given only once daily, they can usually be given at home. However, the day care staff can assure that parents are aware that fluoride supplements are needed by infants fed ready-to-feed formulas and breast milk. After the infant is weaned, if fluoride is present in the drinking water, further fluoride supplementation is not required. However, infants residing in areas where fluoride is not in the drinking water will need continued fluoride supplements.

Sample Menu Plans

Newborn to Five or Six Months

Feed on demand in approximately three to five hour intervals, four to six ounces of breast milk or formula.

At Five or Six Months

Breakfast: infant cereal (start with one or two tablespoons dry cereal diluted with breast milk or formula). Breast milk or formula - up to 8 ounces per feeding.

Snack: water or juice, 2 to 4 ounces (diluted half and half with water) with a finger food.

Lunch: mashed, blenderized or finely chopped vegetables and/or fruit. Infant cereal may also be of-

fered. Breast milk or formula up to 8 ounces.

Mid-afternoon snack: Water or juice, 2 to 4 ounces (diluted half and half with water) with a piece of finger food.

Supper: infant cereal, mashed, blenderized or finely chopped fruit. Breast milk or formula - up to 8 ounces.

Bedtime: Breast milk or formula - up to 8 ounces.

Seven to Twelve Months

Follow the same pattern as at five to six months, progressively substituting soft cooked and minced table foods for mashed or blenderized foods. At twelve months, if not already done, weaning from bottle or breast should be initiated. After twelve months, milk can be offered from the cup with meals. Infants may seem to demand less milk as their solid food content increases.

VI environmental design

The Physical Environment – Powerful Regulator of Experience

By Elizabeth Prescott

Anytime I encounter children who have been in a child care center, I ask them what they remember about it. Invariably their memories are about the agony of lying still at naptime, playing in the sandpile, having to eat beans, having one's back rubbed at naptime, or being outside on hot days. Apparently, their memories are stored primarily as tactile-sensory impressions.

This phenomenon suggests to me the importance of paying attention to the physical environment we create in a child care program. In this article I would

like to address five key dimensions of environment which impact on the experiences of children. Then I will demonstrate how to consider these dimensions in solving some typical problems in child care settings.

DIMENSIONS OF THE ENVIRONMENT

Softness/Hardness. Softness is provided for in a center's environment through the presence of objects which are responsive to one's touch--which provide a variety of tactile sensory stimuli. Such objects include sand, water, grass, swings, rugs, pillows, soft furniture such as large pillows and couches, finger paints, play dough/clay, and laps to sit on. A common characteristic of these "soft" materials is that they provide experiences where the environment responds to the child. You can use your body the way you want to on a rug. You push sand around or pound on clay, and each

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does what you want it to do.

Hard surroundings (tiled floors, wooden furniture, asphalt playgrounds) provide a different experience. You just don't feel as comfortable sitting on a tiled floor, and you don't feel inclined to roll around on an asphalt play yard. In like manner, a straight hard chair tells your body what to do.

These hard materials give the message that "you better shape up and do what the environment requires"--it's not going to give in to you. I think young children are not developmentally ready for this message for very much of the day. Especially in a full day program, inhabitants--big and little--of a hard environment will inevitably experience tension and fatigue.

Open/Closed. Play equipment that is open has no one right way of using it--it can be manipulated in a variety of ways. For example, sand, collage materials, and dress up clothes can be played with in a wide variety of ways--none of these ways is inherently incorrect.

Closed equipment, on the other hand, can only be played with in one way; it can only be manipulated one way to come out right. With a puzzle, for example, the pieces must be fitted the proper way to complete the puzzle. Lotto games and nearly all Montessori equipment exhibit this closed nature. Such equipment is useful and can give a sense of competence, but only if it is well-matched to a child's growing edge--if a child has learned how to do the one operation, it is no longer interesting; and if he can't do it at all, it is often frustrating.

Then there is some equipment which is in-between. Legos and tinker toys are good examples. They require you to pay attention to their qualities. They won't do everything you want them to do. But if used in the proper way, they permit some opportunity for creativity.

I feel that a center needs to provide all these kinds of experiences for children. But for preschool children it is es-

pecially important to have open equipment available. Sometimes centers believe they are well-equipped if they have lots of puzzles and cognitive games. Often open equipment is considered less important and is provided in a haphazard, thoughtless way. The opportunities available in open equipment need to be taken seriously.

Simple/Complex. Play equipment can differ in its holding power, i.e. the capacity to sustain attention. We have called this dimension complexity and have rated play units according to the number of different materials which are combined. A simple unit has one manipulable aspect, a complex unit has two different kinds of materials combined, and a super-unit has three different kinds of materials that go together.

For example, a sand pile with no equipment is a simple unit. Add digging equipment and it is a complex unit. If you add water as a third element, it becomes a super-unit. Play dough by itself is a simple unit. With toothpicks it is a complex unit, and with toothpicks and cookie cutters it's a super-unit.

The advantage of a super-unit is that it is much more complex so that it holds children's interest for a much longer time. As you add more features or materials to a unit, you geometrically increase the number of things that can be done with it. The usefulness of this concept is that when you look at play that isn't working well, you can often get it to work better by making it more complex.

Intrusion/Seclusion. This dimension describes opportunities for privacy and control over one's own territory.

To me this is an especially important issue in day care. It is one thing for a child to go to a morning nursery school, where the main goal is to give the child a social experience. But a child going to a day care center where he has to

deal with many people for an entire day may get much more of a social experience than he needs. For this reason I think it is especially important to have the environment set up with places where children can be alone at times or alone with a best friend or adult, so that they can feel secure that they are not going to be intruded upon. In day care it is important for children to know there are times when they do not have to share and can use equipment without interruption and can have some individual adult attention.

High Mobility/Low Mobility. This aspect looks at the freedom a child has to move around. High mobility activities permit the child to use his whole body--running, climbing, or trike-riding. Other activities, such as story time and puzzles, by their very nature, require children to sit still. There are also activities that are in-between--playing in the house-keeping area or the block corner.

One thing I've observed in cognitively-oriented day care centers is that children are sometimes sitting for long periods of time. I remember observing in a center once where children sat for a matching game at tables, then moved to a story time on a nearby rug, and back to a sitting down activity at the tables. In all, the children had to sit still for nearly two hours which was very difficult for them. The teacher, who was moving about the entire time, apparently wasn't aware that she had provided three low mobility activities in a row.

I've also noticed in centers where children are provided many choices, there are a number of children who will never choose sitting down activities. One thing adults have to be more inventive about in such circumstances is in providing cognitive activities which permit high mobility. There are many counting games that you can do while you're running or trike-riding. Also, with trike-riding, building in stop signs, a trike-riding path, or inventing slalom games are all ways of making children pay attention to perceptual cues. In many centers you only have to pay that kind

of attention in sitting down activities.

DEALING WITH PROBLEMS ENVIRONMENTALLY

Problem: Children not sharing.

There are two spatial problems that are apt to be involved in sharing. One is that there often isn't enough to do. In our observations we counted the number of things to do against the number of children in a center. We found that during a free choice period it actually takes about five things per child at any given time to make for a really well-functioning program. If there were only two things, we would invariably see sharing problems.

The second spatial problem often associated with sharing is insufficient complexity. For example, if children are fighting over tricycles, often the answer is not to get more tricycles but to provide variety in the type of wheel toy and props to go with them. If you have some tricycles with rear seats and some with wagons that hook on, if you have traffic signs and gasoline pumps and perhaps some blocks that can be piled on the wagons, then this activity can absorb far more children without having them fight over the use of the trike itself. Some can be riding, some directing traffic, some hooking on wagons, and some piling on blocks. The resulting play will have a richness of theme seldom seen where only simple tricycles are provided.

Problem: Children not becoming involved.

When children cannot find something to do or are bored with an activity, the problem often can be solved by increasing the complexity of play units, thus adding novelty and providing more focus. If you've had play dough out for a long time, bringing in buttons and toothpicks will add to its interest.

Non-involvement may also be the result of poor organization of the play space

resulting in excessive intrusion. If activities are arranged around the edges of a rectangular room with empty space in the middle, it is likely that children will be drawn out of the activities and into the open empty middle to run. Also a problem will arise if you have an activity area which is not well-protected so that children moving from one activity to another move through it. This traffic will disrupt and discourage the children playing in this area.

Therefore, it is crucial to provide activity areas which are well-defined and well-protected. I would recommend taking a look at your room and yard to determine if there are clear functional pathways between areas. It may be helpful to get down at children's height to view the area as they see it. This perspective may reveal visual obstacles which are not apparent from the adults' eye level.

Problem: A child keeps repeating one activity.

If a child really seems to be stuck on an activity and is in clear need of having his activity level broadened, a look at the environment may suggest some alternatives which provide a secure way for the child to make a move. First you may want to introduce some novelty into the environment. If a child is stuck on puzzles at a certain table, it may help to simply move the puzzles away for a week and to experiment with placing a more open activity such as collage or drawing with felt pens on the table where puzzles have always been located.

Second it may help to restructure the activity. If a child plays continually with play dough as a means of avoiding social contact, it may help to bring the social contact to the clay dough and to protect the budding relationship from intrusions. This child is probably not ready for the complexity of social skills that comes with fast moving, high mobility dramatic play but could handle a bit of interaction over a "safe" activity.

Problem: Children coming unglued at the end of the morning.

I've seen some interesting solutions to this problem. Usually the solutions provide for increasing softness. For example, having children take their shoes off before lunchtime is a way of letting them wind down and of letting them know there is a different part of the day coming. I also remember a center where children were really at loose ends after the usual end of the morning cleaning-up and washing-up. Each adult then took her children into a quiet enclosed area that had a rug and pillows. They had a nice intimate time together--talking or reading stories. The children lounged on the pillows and were relaxed and calm for lunch and naptime.

Problem: Adults coming unglued at the end of the day.

One thing that really surprised me in our observations was that it is the adults more than the children who have a difficult time coping with the final hours of the day. We started out assuming it was the children who fell apart. But we found that after the children got up from their naps, they were raring to go again. When we coded their behavior, they did quite well. In center after center we found it was the adults who appeared fatigued and less effective.

Child care programs will go to a great deal of trouble and expense to provide activities and equipment they think are good for children. But it wouldn't occur to them to get a really comfortable easy chair for an adult who has been there for eight hours.

Likewise, I know of centers where adults may not sit down when children are outside. To me this is not a wise policy--a yard ought to be safe enough so that an adult can sit down. Just as with the easy chair inside, once the adult sits down, she really becomes accessible to children. When an adult is sitting, she can snuggle and converse in a close way which is impossible when she is standing up.

If you want an adult to nurture children, she's got to feel that she's nurtured too. I think providing comfortable furniture and encouraging the adults to be comfortable is one way that you get good things to happen for children.

Another way of saying this is to propose that the dimensions which I have discussed can be applied to enhance the comfort and interest of the environment for adults in day care. They, too, need softness, complexity, variety, and freedom from too much intrusion.

Further Readings:

Elizabeth Jones and Elizabeth Prescott,
Dimensions of Teaching--Learning
Environments--II. Focus on Day Care.
Order from Pacific Oaks College Bookstore
5 Westmoreland Place, Pasadena, CA
91103. \$2.50 plus \$.50 postage and
handling.

Sybil Kritchevsky and Elizabeth Prescott
with Lee Walling, Planning Environments
for Young Children: Physical Space.
Order from Publications Dept., NAEYC,
1834 Connecticut Ave, NW, Washington,
DC 20009. \$1.75 plus 10% postage and
handling.

The Design Process for an Infant-Toddler Environment – A Case Study

by Robert Lurie

In 1974 the Summit Child Care Center had a unique opportunity. As a result of a capital funding drive, the agency was able to design and construct a child care facility from the ground up. The final plan was the result of thousands of hours of research, program evaluation, needs assessment, and professional consultation. When finished in 1976, the building immediately attracted state and national attention for its innovative design.

Four years later the center made significant changes in the plan of the infant/toddler section of the building. This decision was based less on the failure of the original design process than on the changes that had taken place in the organization and operation of the infant/toddler program. The space no longer met the needs of the program.

The experience at the Summit Child Care Center demonstrates the close and necessary relationship between program organiza-

tion and the design and use of space. An analysis of the process leading to the revised plan also pinpoints some of the critical environmental parameters for quality group infant/toddler care.

THE ORIGINAL PLAN

The infant/toddler components in the new building were assigned to a rectangular space of approximately 2000 sq feet. The original conception was for the program to be split into an infant component of 22 children based in two "nursery" areas and a toddler component for 15 children based in a "toddler playroom." (See Plan A) The infant nurseries contained cribs or trundle beds for each child, the tables and chairs necessary for eating and activities, housekeeping areas, water tables, easels and other basic equipment. The toddler room was "self-contained" and included all the necessary program

elements.

The infant/toddler space was essentially one large room, with no interior partitions and an exposed truss ceiling. The two components were physically divided by the center's resource/media room which was carved out of the rectangle and by a specially constructed "infant environment"--a fixed carpeted structure including tunnels, ramps and platforms. However, there were no complete visual or sound barriers in the combined space.

A stated goal in the design of the building had been "openness and flexibility." The funding slogan was "open spaces and private places." Those involved with the project expressed a resistance to small enclosed rooms along a hallway. However, sometimes this enthusiasm for openness led to design decisions which later proved detrimental to the needs for privacy already recognized. As an example, folding doors were left off the final plans for the infant nurseries, because they would be too "confining." As you will see, later this very need for confinement and more controlled spaces help bring about changes in the plan.

DESIGN FEATURES

Because the building was built for day care there were several unique features. The cribs and trundle beds were designed and built by local carpenters. The cribs were set on a formica shelf around the edges of the room and could be folded up when not in use, leaving a large table-height activity area. The trundles rolled under the shelf when not in use and were used for storing a variety of supplies. Each room contained changing counter/cabinets built to a height comfortable for the caregivers and with its own sink.

Some ideas were less successful. A trash compactor was included in one changing cabinet for use with disposable diapers.

It never worked properly (disposable diapers tend to pop back up after being compacted) and was a sanitary and odor problem when it was used.

CHANGING PROGRAM REALITIES

The original needs assessment for the building projected a great demand for infant care. In actuality few very young infants came into the program--most children were at least 18 months old and many were already two. This practical fact forced a reconsideration of the program organization. In this context of a different actual population, a careful analysis of developmental and program needs resulted in a decision to regroup the children heterogeneously by age and to combine the infant and toddler components into one program. This "family-like" grouping eliminated an artificial and often wrenching move between programs, allowed a more individualized caregiver focus, and promoted a better use of the overall space.

In the revised organizational plan, all children slept in the former infant nurseries, freeing up the former toddler space to serve as a general purpose activity area used by all. Tracking groups were created consisting of one caregiver and four or five children of different ages. These children ate and met together and were informally "based" throughout the total space. The tracking teacher monitored the progress of the children in their group and developed a close and consistent relationship.

CONTINUING PROBLEMS

Despite these steps to respond organizationally to the changing program realities, the design continued to present operational problems. Due to the lack of interior partitions and defined enclosing spaces, the program tended to function as one large group of 37 children sharing one large room. Caregivers spent a great deal of time and energy trying to control and focus children's movements and to create artificially, with equipment and toys, smaller more comfortable groups. Children tended to wander and sometimes get "lost"--out of the focus of the caregivers. Noise levels were high, caregivers sometimes tense, and the enormity of the space with its high ceilings and few walls tended to make

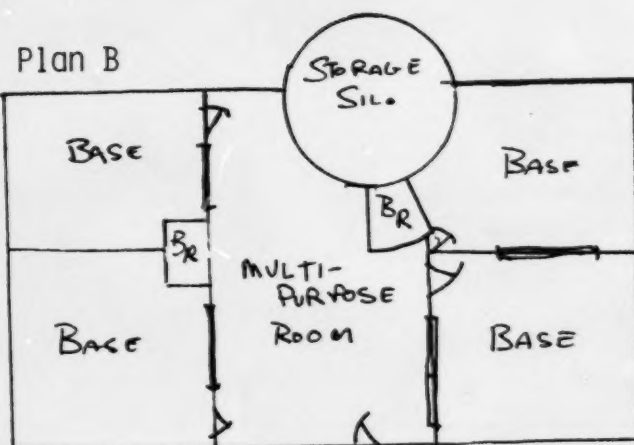
separation more difficult. In general, while the program was viewed positively by parents and observers, this was true because of the quality of the caregiving and in spite of the setting.

DECISION TO CHANGE

After three years in the building and many efforts to deal creatively with these problems, it became clear that organizational solutions would not suffice. When this reality was accepted a new evaluation assessment process took place to define the issues and identify potential solutions. As a result of the process, a decision was made to create relatively self-contained and enclosed home bases to serve small groups of children. In addition to experience-based data pointing in this direction one powerful impetus was the opening of a second infant/toddler program in former public school classrooms. The more defined spaces with small groups of children actually functioned better than the agency's own building. Another confirming impulse was the National Day Care Study which emphasized the importance of small groups in determining quality care. While the study said little about the impact of varying environments on quality, the documentation it provided on the importance of small groups, combined with the center's own data on the infant/toddler's need for a definable controlled environment was conclusive.

THE NEW PLAN

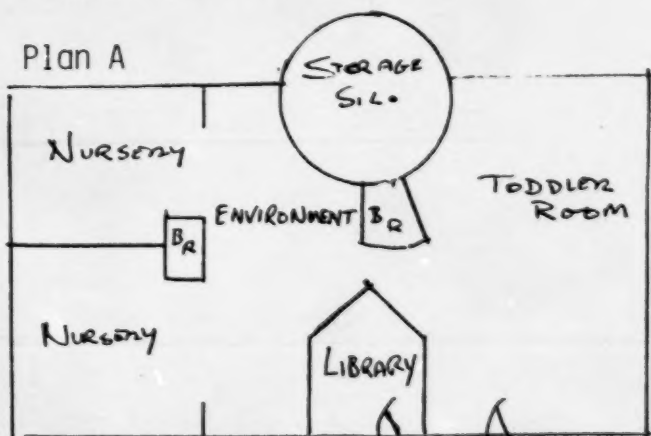
In the winter of 1980 the infant/toddler space was modified. Four self-contained



home bases were created, each serving ten children (two tracking groups) and two caregivers (see Plan B). The basic needs of sleeping, eating, changing take place along with many of the structured and informal play activities in the base area. Each base has a changing counter with sink, cubbies for each child, a carpeted area, and tables and chairs. By dismantling the fixed and inflexible environment and by moving the center library to another area of the building, an impressive and multi-purpose "big room" was created between the bases to provide space for large muscle play, art and housekeeping areas and too meet a variety of program needs.

Due to the open construction, these modifications were accomplished without an impact on the building's mechanical systems (heat, air, etc.) and simply required a few new non-load bearing walls. Much of the material and equipment from the earlier plan was reused, including the cribs on shelves (two to each base), windows and blinds (each base has a window opening into the "big room.")

It is too early to evaluate the impact of the combined physical/programmatic changes, but already the children and caregivers seem in greater focus and the tone is quieter and more relaxed. While children still cry and caregivers still get frustrated, there is a definite positive feeling that many program goals are within reach.



VII bibliography

OVERRIDING ISSUES

Brazelton, T. Berry. Infants and Mothers: Differences in Development. New York, NY: Dell Publishing Company. 1969.

Brazelton, T. Berry. Toddlers and Parents: A Declaration of Independence. New York, NY: Dell Publishing Company. 1974.

Bromwich, Rose M. "Stimulation in the First Year of Life? A Perspective on Infant Development." Young Children. January, 1977.

Caldwell, Bettye M. et al. "Infant Day Care and Attachment." American Journal of Orthopsychiatry. 1970 (#40-3).

Caldwell, Bettye M. "What Does Research Teach Us About Day Care for Children Under Three?" Children Today. 1972:1.

Clarke-Stewart, Alison. Child Care In the Family. New York, NY: Academic Press. 1977.

Elardo, Richard and Betty Pagan (Eds.). Perspectives on Infant Care. SACUS, Box 5403, Brady Station, Little Rock, AR 72215. (111 pages, \$4).

Fraiberg, Selma H. Every Child's Birthright: In Defense of Mothering. New York, NY: Bantam Books. 1977.

Frank, Lawrence. On the Importance of Infancy. New York, NY: Random House. 1966.

Galinsky, Ellen. "Infants and Toddlers in Day Care: How Do They Turn Out?" Working Mother. May, 1980.

Galinsky, Ellen and William Hooks. The New Extended Family: Day Care That Works. Boston, MA: Houghton-Mifflin. 1977.

Kagan, Jerome et al. Infancy--Its Place in Human Development. Cambridge, MA: Harvard University Press. 1978.

Keister, Mary Elizabeth. The Good Life: for Infants and Toddlers. 1977. NAEYC, 1834 Connecticut Avenue, NW, Washington, DC 20009. (48 pages, \$1.75 plus 10% shipping.)

Tyler, Bonnie and Laura Dittman. Meeting the Toddler More than Halfway. Young Children. January, 1980.

White, Burton L. The First Three Years of Life. Englewood Cliffs, NJ: Prentice-Hall, Inc. 1975.

CURRICULUM DEVELOPMENT

Anselmo, Sandra and Jane D. Petersen. A Manual for Caregivers of Infants and Toddlers. R & E Associates, Inc., 936 Industrial Avenue, Palo Alto, CA 94303. (77 pages, \$6.)

Denenberg, V. H. (Ed.). Education of the Infant and Young Child. New York, NY: Academic Press. 1970.

Dunn, Judy. Distress and Comfort. Cambridge, MA: Harvard University Press. 1977.

Fowler, William. Infant and Child Care: A Guide to Education and Group Settings. Boston, MA: Allyn and Bacon. 1980.

Gesell, Arnold, Frances Ilg, and Louise Bates Ames. Infant and Child in the Culture Today: The Guidance of Development in Home and Nursery School. New York, NY: Harper and Row. 1974.

Honig, Alice and J. Ronald Lally. "How Good Is Your Infant Program?" Child Care Quarterly. 1975 (#4-3).

Jacobson, Arminta Lee. "Infant Day Care: Toward a More Human Environment." Young Children. July, 1978.

Kock, Dr. Jaroslav. Total Baby Development. New York, NY: Pocket Books. 1976.

Lally, Dr. J. Ronald and Dr. Ira J. Gordon. Learning Games for Infants and Toddlers. Syracuse, NY: New Readers Press. 1977.

Lehane, Stephen. Help Your Baby Learn: 100 Piaget Based Activities for the First Two Years of Life. Englewood Cliffs, NJ: Prentice-Hall, Inc. 1976.

Lischner, Kyong et al. Developmental Play as a Learning Tool--Birth to Three Years: Curriculum Guide for Infant-Toddler Education Program. Glassboro, NJ: Bozorth Early Childhood Center, Glassboro State College. 1975.

Smart, Mollie S. and Russel C. Smart. Infants: Development and Relationships. (2nd Edition). New York, NY: Macmillan Publishing Co. 1978.

Stone, L. J. and J. Church. Childhood and Adolescence. (3rd Edition). New York, NY: Random House. 1973.

Tronick, E. and P. M. Greenfield. Infant Curriculum. New York, NY: Media Projects. 1973.

Vallery, Arlee. Stimulating Group Care for Infants and Toddlers. 1972. Independent Study, Box 2967, The University of Alabama, University, AL 35486. (42 pages, \$1.00.)

STAFF DEVELOPMENT

Building Skills for Day Care of Infants (Monograph 9). New York, NY: Institute for Child Mental Health. 1973.

Day Care Personnel Management. Child Care Support Center, Save the Children, 1182 W. Peachtree St., NW, Atlanta, GA 30309. (82 pages, \$4.)

Dittmann, Laura (Ed.). The Infants We Care For. 1973. NAEYC, 1834 Connecticut Avenue, NW, Washington, DC 20009. (108 pages, \$2 plus 10% shipping.)

Feeney, Stephanie and Doris Christensen. Who Am I in the Lives of Children? Columbus, OH: Charles E. Merrill Publishing Co. 1978.

Honig, Alice and J. Ronald Lally. Infant Caregiving: A Design for Training. Children's Center, 100 Walnut Place, Syracuse, NY 13210. (224 pages, \$12.50.)

Honig, Alice. "What You Need To Know to Select and Train Your Day Care Staff." Child Care Quarterly. Spring, 1979.

Jones, Elizabeth. "Creating an Environment in Which Adults, Like Children, Learn Through Play." Child Care Information Exchange. April, 1980.

Lally, J. Ronald and Bettye M. Caldwell. "Training Paraprofessionals for Work with Infants and Toddlers." Young Children. 1973 (Vol. 28).

McGregor, Douglas. The Human Side of Enterprise. New York, NY: McGraw-Hill Book Company. 1960.

Neugebauer, Roger. Organizational Analysis of Day Care. ERIC Document Reproduction Service, PO Box 190, Arlington, VA 22210. (85 pages, \$5.33.)

Rogers, Carl. Freedom To Learn. Columbus, OH: Charles E. Merrill Publishing Co., 1969.

Schein, Edgar H. Organizational Psychology. Englewood Cliffs, NJ: Prentice-Hall. 1965.

Steinmetz, Lawrence L. Managing the Marginal and Unsatisfactory Performer. Reading, MA: Addison-Wesley Publishing Company. 1969.

Wasserman, Selma. "The Open Classroom in Teacher Education." Childhood Education. March, 1973.

Willis, Anne and Henry Ricciuti. A Good Beginning for Babies: Guidelines for Group Care. NAEYC, 1834 Connecticut Avenue, NW, Washington, DC 20009. (194 pages, \$4.50 plus 10% shipping.)

PARENT RELATIONS

Caplan, Frank. The Princeton Center for for Infancy (Ed.). The Parenting Advisor. Garden City, NY: Anchor Books. 1978.

Carmichael, Carrie. Non-Sexist Child-Raising. Boston, MA: Beacon Press. 1977.

Fein, Greta G. "Infant Day Care and the Family: Regulatory Strategies to Ensure Parent Participation." FIDCR Appropriateness Study State of the Art Paper, Washington, DC: DHEW-Office for Planning and Evaluation. 1977.

Gordon, Ira. Baby to Parent, Parent to Baby. New York, NY: St. Martins Press. 1977.

Honig, Alice. Parent Involvement in Early Childhood Education. NAEYC, 1834 Connecticut Avenue, NW, Washington, DC 20009. (105 pages, \$3.30.)

Infant Development Guide. Johnson and Johnson Baby Products, 6 Commercial St., Hicksville, NY 11801. (450 pages, \$10.84.)

McDiarmid, Norma J. et al. Loving and Learning: Interacting with Your Baby from Birth to Three. New York, NY: Harcourt, Brace, Jovanovich. 1975.

McLaughlin, Clara. Black Parents Handbook: A Guide to Healthy Pregnancy, Birth, and Child Care. New York, NY: Harcourt, Brace, Jovanovich. 1976.

Painter, Dr. Genevieve. Teach Your Baby. New York, NY: Simon and Schuster. 1971.

Pulaski, Mary Ann Spencer. Your Baby's Mind and How It Grows: Piaget's Theory for Parents. New York, NY: Harper and Row.

Schaffer, Rudolph. The Developing Child: Mothering. Cambridge, MA: Harvard University Press. 1977.

Segal, Marilyn and Don Adcock. From Birth to One Year, From One to Two Years, Play and Learning, and Social Competence. (four books in a series.) B. L. Winch and Associates, 45 Hitching Post Drive, Blg. 2, Rolling Hills Estates, CA 90274.

Sroufe, Alan E. Knowing and Enjoying Your Baby. Englewood Cliffs, NJ: Prentice-Hall, Inc. 1977.

Stern, Daniel. The Developing Child: The First Relationship--Infant and Mother. Cambridge, MA: Harvard University Press. 1977.

Stevens, Jr., Joseph H. and Marilyn Mathews (Eds.). Mother/Child, Father/Child Relationships. NAEYC, 1834 Connecticut Avenue, NW, Washington, DC 20009. (258 pages, \$5.25.)

NITTY GRITTY

Aronson, M.D., Susan and Hannah Nelson, R.N. Health Power: A Guide to the Health Component of Early Childhood Programs. Department of Community and Preventive Medicine, Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia, PA 19129. (\$5.75.)

Aronson, M.D., Susan and Peggy Pizzo.
"Health and Safety Issues in Day Care."
FIDCR Appropriateness Study State of the
Art Paper. Washington, DC: DHEW-Office
for Planning and Evaluation. 1977.

Bogart, L. J. et al. Nutrition and
Physical Fitness. Philadelphia, PA:
W. B. Saunders. 1973.

Boston Children's Medical Center. Child
Health Encyclopedia. New York, NY:
Dell Publishing Co. 1975.

Fomon, Samuel J. Infant Nutrition.
(2nd Edition). Philadelphia, PA:
W. B. Saunders. 1974.

Green, Martin I. A Sigh of Relief: The
First Aid Handbook for Childhood Emer-
gencies. New York, NY: Bantam Books.
1977.

Huntington, D. S. et al. Day Care 2:
Serving Infants. Washington, DC:
US Government Printing Office. 1971.
(DHEW Publication #OCD 72-8.)

"Introducing Solid Foods to Infants."
Child Care Resources. January, 1980.
Karen West, 79 Fruit Hill Drive,
Chillicothe, OH 45601.

Levy, Dr. Janine. The Baby Exercise
Book--For the First Fifteen Months.
New York, NY: Pantheon Books. 1975.

Nutrition and Feeding of Infants and
Children Under Three in Group Day Care.
Washington, DC: US Government Printing
Office. 1971. (DHEW Publication
No. HM72-5606.)

Schiller, M.D., Jack G. Childhood Ill-
nesses. New York, NY: Day Books.
1979.

"Standards for Day Care Centers for
Infants and Children Under 3 Years of
Age." American Academy of Pediatrics,
1801 Hinman Avenue, Evanston, IL 60204.

ENVIRONMENTAL DESIGN

Evans, E. Belle and George E. Saia. Day
Care for Infants. Boston, MA: Beacon
Press. 1972.

Kritcheusky, Sybil and Elizabeth Prescott.
Planning Environments for Young Children:
Physical Space. NAEYC, 1834 Connecticut
Avenue, NW, Washington, DC 20009. (\$2.)

Jones, Elizabeth (Ed.). Supporting the
Growth of Infants, Toddlers and Parents.
Pacific Oaks Bookstore, 5 Westmoreland
Place, Pasadena, CA 91103. (80 pages,
\$5.50.)

Jones, Elizabeth and Elizabeth Prescott.
Dimensions of Teaching-Learning Environ-
ments--II. Focus on Day Care. Pacific
Oaks Bookstore, 5 Westmoreland Place,
Pasadena, CA 91103. (\$4.)

Herbert-Jackson, Emily et al. The Infant
Center: A Complete Guide to Organizing
and Managing Infant Day Care. Baltimore,
MD: University Park Press. 1977.

Sale, June. Programs for Infants and
Young Children. Part IV: Facilities
and Equipment. Washington, DC:
Appalachian Regional Commission. 1970.

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